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ABSTRACT

A study reviewed and compared initial and renewal practices for licensure/registration of 13 health care occupations regulated in the state of Minnesota. It examined mandatory continuing education (MCE) documentation and the practices of licensing boards in their enforcement of the MCE legislation. The Minnesota Statutes and Rules for the following 13 health care occupations were reviewed: (chiropractor; dental assistant; dental hygienist; dentist; marriage and family therapy; nurse; optometry; pharmacy; physical therapy; physician assistant; physician and surgeon, osteopath; podiatry; and social work). A data summary sheet developed for each occupation included initial requirements and continuing education renewal requirements. Executive directors were interviewed to clarify and expand on the data. Documents provided by licensing board staff were examined and reported on the data summary sheets. Findings indicated that two types of legal regulation were used: licensure and registration. The initial licensure requirements included minimum levels of schooling and completion of specific examinations for all 13 occupations. Renewal requirements were as follows: a reporting cycle ranging from 1-5 years; 15-75 hours required per cycle; and approved educational activities consisting of classroom/workshop and self-directed learning and independent study. Nine occupations used a program approval process; four used audits. Few disciplinary actions were taken as a result of failure to comply with the MCE requirement. The findings suggested that adult educators could assist professionals and licensing boards through needs assessment and program design. Appendixes include forms, and data summary sheets. (Contains 48 references.) (YLB)

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UNIVERSITY OF MINNESOTA

A COMPARISON OF THE MANDATORY CONTINUING EDUCATION [MCE] REQUIREMENTS OF THE REGULATED HEALTH OCCUPATIONS IN MINNESOTA

A FOUR CREDIT PLAN B PAPER
PRESENTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OF ARTS

BY
BETH GREEN-EIDE

MINNEAPOLIS, MINNESOTA
JULY 1991

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CHAPTER 1
INTRODUCTION

With the major changes in technology that are taking place in health care today, health care occupations are seeking and gaining legal credentialing in Minnesota. Within the next two years, the occupations of Contact Lens Technicians, Hearing Instrument Dispensers, Occupational Therapy, Respiratory Care, Speech Language Pathologists and Audiologists will be legally recognized and regulated by the state of Minnesota. Beginning with 1991, Hearing Instrument Sellers will be required to register for a permit which will allow them to dispense hearing aids. A voluntary registration system will begin for Hearing Instrument Dispensers. The rules for the registration of Respiratory Care practitioners are complete and practitioners will start to register in December of 1991. The rules for Speech Language Pathologists, Audiologists, and Occupational Therapy, are being written and registration will start near the end of 1991 or begin in 1992. Contact Lens Technicians will begin registration in 1992.

A regulated health care occupation is defined as licensed or registered in the state of Minnesota. When an occupation is licensed, it is illegal to practice or perform any duties characteristic of that occupation without a license. When an occupation is registered, it is illegal to use the registered title unless one is registered. The primary goal in regulating a health occupation or any other occupation for that matter is to protect the public from harm due to incompetent practitioners. These regulations require minimum education levels for entry into the profession and, often times, continuing education requirements for renewal of the license or registration. In addition to education requirements, either a state or national examination must be completed as part of the initial license or registration. There may also be requirements for work experience such as an internship and for proof of good moral character such as letters of reference. All of these requirements in the regulations are

designed to establish a minimum level of competence of the practitioners working in the occupation and thereby protect the public from harm.

Practitioners in regulated occupations must also renew their licenses (i.e., recredentialing) according to the state law. There are several goals which recredentialing should achieve (Gray 1984). The primary goals of recredentialing are to maintain practitioner competence and to protect consumers from harm by unqualified practitioners. Some of the secondary goals of recredentialing include: 1) improving the quality of services delivered by the practitioners, 2) enabling employers, third party payors, and consumers to easily identify experienced health care practitioners who have demonstrated that they have maintained current entry level knowledge and skill, and 3) encouraging the professional growth and job satisfaction of the health care practitioner (Gray 1984).

Mandatory continuing education (MCE) or continuing education which is required of all practitioners is one means used by practitioners for license/registration renewal. For example, a licensed pharmacist in the state of Minnesota must complete 30 hours of continuing education every two years in order to maintain a valid license.

In addition to continuing education which is required as a part of state regulations, education may also be mandated to obtain professional memberships, to meet employment requirements, or to acquire certificates (Rockhill 1983). For example, the American Association of Marriage and Family Therapy requires the completion of 15 hours of continuing education to be a member of the National Association of Marriage and Family Therapy. As for employment requirements, the teaching profession is a prime example of an occupation using continuing education as a basis for salary increases. Teachers must complete a certain number of college credits to be eligible for a lane change which results in salary increases. One use of certification requirements is by the American Board of Family Practice; this Board requires 150 hours of continuing education every three years to maintain one's certification as a board certified family practice physician.

There is much controversy over the effectiveness of MCE (Rockhill 1983, Young and Willie 1984, Frye 1991, Phillips 1987, Stross and Harlan 1987). The philosophical debate centers on the question, "Does MCE maintain practitioner competence"? The extent that continuing education has improved skills has not been well researched. Rockhill (1983) reports that underlying the argument about professional obsolescence is the concern that professionals be competent in their area of practice and that existing methods of assuring competence have not been proven effective.

Young and Willie (1984) reviewed the literature which studied effectiveness of continuing education in the health occupations. The results of this review indicate that continuing education promoted continuing competence of health professionals in making decisions and in providing better patient treatment. But, the continuing education system often failed to identify the needs of participants, to match individuals with pertinent programs, and to monitor the quality of programs.

Gray (1984) categorizes the critical issues surrounding recredentialing as professional, financial, legal, and technical. She states that :

> Professional issues are concerned with identification of needs and clarification of goals. Financial questions are raised in regard to costs to everyone in the health care system and the cost benefit ratio of a recredentialing program. Legal issues deal primarily with the implications of the denial of a credential on the right to work. Discussions of technical issues address the state of the art and science of competency assessment.

PROBLEM

Mandatory continuing education has become a standardized activity in the state regulatory process but the types of education activities which are accepted by state boards vary from occupation to occupation. Some of these activities include: attending workshops/conferences, journal reading, completing home study programs, presenting lectures, writing journal articles or books, or attending patient teaching rounds. By far the most common is the traditional lecture type educational activity (Puetz 1983, Stross 1987,

Osborne 1988, Stross and DeKornfeld 1990). In fact, some state boards will not approve any other form of educational activity.

In addition to the differences in type of activities and in the amount and type of programs, the approval mechanisms and evaluation systems vary greatly among the occupations and from state to state. States vary in their disposition toward requiring continuing education. A 1982 study of the number of occupations by states which reported continuing education requirements found a range from 15 occupations (in Iowa) to only two occupations (in Missouri, New York, and the District of Columbia) (California State Postsecondary Education Commission 1982).

In order to accomplish the goal of protecting the public through demonstration of continued competence, adult and continuing education experts in the occupations need to review the MCE practices and develop sound policies which regulate MCE . Little has been presented in the literature about how MCE is monitored, evaluated and enforced by licensing boards. Some of the questions surrounding MCE for health occupations in the state of Minnesota for which information is needed to guide policy and practice are as follows:

What kinds of MCE activities are required by the health care occupations in Minnesota?

Is preapproval of programs required?

Are objectives required?

Who are the providers for continuing education in the health occupations?

Is prior approval of providers required?

Is evaluation an integral part of the continuing education process? Are pre and post tests required?

What documentation is required for proof of attendance?

What happens if individuals do not meet the MCE requirements for renewal and how often does this happen?

There are no reports in the literature that describe the rationale for the amount of continuing education which is required by an occupation. Finally, there is little in the

literature which outlines in detail the procedures for approving programs, monitoring of licensees/registrants, types of evaluation mechanisms, documentation and enforcement of MCE which are utilized by state licensing boards.

PURPOSE

The purposes of this study were to identify and compare components of MCE of health occupations currently regulated in the state of Minnesota. The investigator explored the initial requirements for licensure/registration, the renewal requirements for licensing/registration including documentation, and the practices of licensing boards in their enforcement of the MCE legislation. Specifically this research study examined:

1. What are the initial licensure requirements for health care professionals regulated in the state of Minnesota?
2. What are the renewal requirements for health care professionals regulated in the state of Minnesota?
3. How is MCE documented?
4. How is MCE enforced?

BACKGROUND

Historically, licensure has been used by state governments as a mechanism to protect the public from harm by incompetent or unqualified practitioners (Gray 1984). In 1967, the National Commission on Health Manpower took note of the problem of obsolescence and suggested that relicensure be based on acceptable performance of continuing education or examination (Shimberg 1977). In 1971, the U.S. Department of Health, Education, and Welfare recommended that states and professional organizations should include specific requirements to ensure continued competence (Shimberg 1977). As a result of this report, many professional organizations and state boards implemented requirements for mandatory continuing education as a requirement for membership or

license renewal/recredentialing. The number of states which required MCE as part of relicensure for selected health occupations in a 1988 study were as follows: optometrists -46, pharmacists -36, physicians -21, social workers -20, dentists -13, nursing -11, licensed practical nurses (LPN) -10, physical therapists - 4 (Osborne 1988).

Although MCE is the most common method of recredentialing, written examinations are used by some occupations for recertification. By 1987, twelve of the 23 medical specialty boards within the American Medical Association (AMA) Specialties had adopted rules that certification (in that specialty) be time limited and that examinations would be the form of recertification (Phillips 1987). Two other methods, peer review/audit and on-the-job-performance evaluations—although not utilized at this time by licensing boards—may become useful methods of recredentialing (Gray 1984). The Joint Commission on Accreditation of Hospital Organizations (JCAHO) requires ongoing peer review/audit to maintain hospital accreditation as a JCAHO hospital (Gray 1984). The effectiveness of peer review/audit as a method of recredentialing is not clear but they have been helpful in identifying and resolving problems (Gray 1984). The problem with performance evaluations lies in the lack of standardized instruments (Gray 1984).

Much of the literature on MCE presents data relating to the controversy of the effectiveness of MCE in maintaining practitioner competence (Rockhill 1983, Frye 1991, Phillips 1987, Stross and Harlan 1987). One author reviewed over 300 articles relating to MCE with only 41 articles meeting his criteria for research design (Beaudry 1989). The research criteria included: studies must include a comparison group in research design, studies with only pre and post test designs were excluded, and studies had to have sufficient statistical analysis to apply techniques for size calculation. The overall conclusion was that MCE had positive outcomes in relation to physician knowledge and performance and patient health status.

In contrast, there are studies which report little change in performance as a result of MCE. A review of the studies of the effectiveness of continuing education in the health

occupations reports that maintenance of professional competency has never been clearly and consistently demonstrated (Young and Willie 1984). Dowling (1985) conducted a mail survey of 1,901 dental hygienists in Wisconsin and Minnesota to determine the impact of mandatory versus voluntary continuing education systems for relicensure on performance. Analysis of the data demonstrated no practical significant difference in performance between the study populations practicing under mandatory and under voluntary continuing education systems. In an analysis of MCE for physicians and lawyers, the author points out that although mandatory continuing education had a positive effect on the knowledge level of medical practitioners, effects on performance were limited and impact on quality of care was unproven (Frye 1990).

Other studies report the opinions of practitioners toward MCE as a requirement for license/registration renewal. A study of the attitudes of Iowa nurses toward the MCE requirement showed that before implementation of the requirement, nurses were generally opposed to MCE. Two years after the implementation of mandatory continuing education, one third of the nurses were favorable toward MCE (Arneson 1985).

There has been only one study by the University of California Extension (1989) which reviewed state licensing and continuing education requirements similar to this study. There were twelve health occupations included in this list. The University of California study reviewed the MCE requirements for licensure renewal for 35 occupations licensed in the state of California. The number of hours required for the health care occupations ranged from 15 hours every two years for the respiratory care practitioners to 50 hours per year in the case of the osteopathic physicians. Seven of the 12 occupations had a two year MCE renewal cycle. This study did not report the renewal process in detail, but did report that five health care occupations approved providers which could then offer unlimited number of courses during the provider contract period.

In summary, the philosophical debate over requiring continuing education for professional practitioners has been a major concern expressed in the literature. Many

studies have reported that MCE does have a positive affect on practitioner knowledge and decision making. MCE does provide the incentive for practitioners to participate in continuing education activities. While the goal of MCE is to maintain practitioner competence, state boards and studies have not reported measured changes in practitioner competence. While needs assessment is not a part of the MCE experience as it exists today, and while it is costly for state boards to monitor individual competence, MCE is still viewed as beneficial.

METHODOLOGY

A search of the medical literature regarding continuing education, licensing and registration renewal was completed. Pertinent Minnesota state documents relating to regulating health care occupations were examined. Several books on occupational licensing were also reviewed.

A listing of the state boards regulating health occupations was obtained from the Minnesota Department of Human Services. The Minnesota Rules and Minnesota Statutes for regulating health care occupations were reviewed to identify those occupations which required continuing education for license/registration renewal. A statute is the law or regulation that the legislature has passed. The statutes describe who, how and by what authority an occupation will be regulated. The statutes are often referred to as practice acts since they also include the scope of practice for the occupation. The rules are written to describe how the statues will be implemented. The rules are more detailed and provide information to practitioners on how to become licensed/registered initially and how to renew their licenses and registrations.

The criteria for inclusion of a health care occupation in the study was as follows: the occupation must be legally recognized in Minnesota either through licensure or registration; practitioners have direct involvement with patient/client care (mental as well as physical); continuing education is required for renewal of the license or registration; and these regulations are administered by a state licensing board. There were a total of 17

occupations or groups regulated by state licensing boards as of January 1, 1991. Psychologists were excluded from the study as they have no MCE requirement. Midwifery is excluded since there have been no applications for midwifery in forty-five years and no one is licensed in the state of Minnesota. Nursing home administrators are not involved in direct patient care and therefore were excluded. Unlicensed mental health practitioners were excluded as they were neither licensed nor registered and did not require continuing education for renewal. This left a total of thirteen occupations which were included in the study.

A data summary sheet was developed to organize the data collected from the review of the statutes and rules. After an initial review of the statutes, key components of the rules were identified. These key components were the initial requirements (schooling, examinations, experience); renewal requirements (hours/years, program approval, provider approval, proof of attendance), and enforcement (disciplinary actions). This review also helped to identify information that was not well defined in the rules (i.e., who writes the examinations, what kinds of examinations are required, what is actually turned in at renewal time, who approves programs, and what happens if MCE is not completed?). This data sheet was subsequently reviewed for accuracy and completeness during an interview with a representative from each occupation.

The state licensing boards' executive directors who are responsible for the enforcement of the rules were targeted to be interviewed. Personal interviews were conducted with eight executive directors representing the 13 regulated health occupations . The ninth executive director would consent only to a telephone interview. Some boards have authority over more than one occupation. The Board of Dentistry regulates dentists, dental hygienists, and dental assistants and the Board of Medical Examiners regulates physical therapists, physicians assistants, and physicians. The executive directors of the Board of Social Work and the Board of Dentistry referred the investigator to an office staff

member responsible for the MCE. The executive director of Nursing referred the investigator to an assistant director.

An interview schedule was developed after completion of the data summary sheets. Questions were designed to verify information obtained from the rules and to clarify actual procedures that the boards used in the implementation and enforcement process. The interview schedule was tested on a former member of the Health Services Occupations Advisory Council which in Minnesota reviews requests for legal recognition from health care occupations and makes recommendations to the Commissioner of Health.

During the interview, information relating to the extent of continuing education required, rationale, quality control factors, types of continuing education accepted, and recommendations for change in continuing education was obtained. The interview was also utilized to clarify the extent of their regulations and other information obtained from rules and statutes.

Using the notes compiled during the interviews, additional information was added to the data summary sheets. Written documents provided by licensing boards were also examined and results were recorded on the data summary sheet. After review of the data, several tables were developed to summarize the characteristics of each occupation.

SIGNIFICANCE OF THE STUDY

The results of this study may assist professionals in comparing MCE procedures throughout the health care occupations to identify practices which will increase the effectiveness and efficiency of MCE. This information may also be useful for health occupations which are in the process of becoming regulated or by state licensing boards to develop effective and efficient MCE procedures. Finally, the results will be beneficial to state boards affecting administrative procedures and the criteria for approving, monitoring, and evaluating activities of educational providers and participants in MCE.

ORGANIZATION OF PAPER

The background of the problem, the purpose of the study, methodology and the significance of the study are described in Chapter 1. A review of the literature on the requirements and effectiveness of MCE is presented in Chapter 2. Chapter 3 details the study design and procedures. The presentation and analysis of data are detailed in Chapter 4. Chapter 5 provides a summary of the study and implications resulting from the data compiled.

CHAPTER 2
REVIEW OF LITERATURE

A search of the literature was completed through use of the Education Research Information Center (ERIC), the Minnesota Medline electronic data bases, the Minnesota Legislative Resource Library which is located at the State Office Building, and the Judicial Library at the Minnesota State Judicial Building. The key terms utilized in these searches were continuing education, health professions, licensure and mandatory continuing education. Although there is much written regarding effectiveness of MCE in the health occupations, little is written describing the practices of licensing boards or comparing MCE practices among professions. There is also some confusion regarding regulations because definitions of regulations will vary.

This chapter will review the background on legal regulation of professional practice, the concept of mandatory continuing education, and the requirements for mandatory continuing education in the health occupations.

Legal Regulation of Professional Practice

Background

The legal regulation of occupations is a state's rights issue. State legislatures use various forms of legal regulations to protect the public from harm. This concept is not new. As early as 1790, physicians in New York City were required to be examined by officials before they could practice. Fines were then imposed on physicians for noncompliance (Kett 1968). Pharmacists have been regulated since about 1886 (Tom Hiendlmayr, telephone interview, May 1991) In the last few years, the implementation of diagnosis related groups (DRGs) and payment practices of third party payors have been impetus behind legal recognition of health care professions. Third party payors (e.g., Blue

Cross Blue Shield, Medical Assistance, Health Maintenance Organizations [HMO]) are using legal recognition by the state to determine what services will be paid. For example, services rendered by a licensed social worker will be paid before services rendered by a nonregulated counselor. Third party payors are less likely to accept private national credentials such as Registered Respiratory Therapist which is awarded by the National Board of Respiratory Care. Therefore, many health care professions are now seeking legal recognition by the State of Minnesota.

In 1976, Minnesota Statue Chapter 214 gave the Minnesota State Department of Health the authority to promote the recognition of human services occupations useful in the effective delivery of human services. A health services occupation means:

> "an occupation whose principal functions are performed customarily for remuneration on behalf of individuals, families, or groups to assist in achieving:
>
> A. optimal economic security through the provision of employment services, income security services, and income maintenance and ancillary supportive service;
>
> B. optimal health through the provision of maintenance, diagnostic, treatment, and ancillary supportive services in the area of physical health, environmental health, mental health, and developmental disabilities;
>
> C. optimal knowledge and skills through the provision of social adjustment services, social development service, protective services, correctional services, services to victims of abuse, neglect, exploitation or crime, and ancillary supportive services (Minnesota Rules 4695.0600, subpart 14).

This statute also gave health-related and non-health related licensing boards authority to "promulgate rule requirements for renewal of licenses designed to promote the continuing professional competence of licensees" (Chapter 214.12 1976).

Types of Regulations

Registration

Registration is defined in Minnesota Rule 4695.0600 subpart 21 as "a system whereby practitioners who will be the only persons permitted to use a designated title are

listed on an official roster after having met predetermined qualifications." This provides title protection only. At the present time in Minnesota, registration is the legal regulation used for title protection of an occupational group. Title protection prevents individuals from using a particular title but not from performing the duties of the occupational group. Registration is considered less restrictive than licensure. This form of regulation is preferred for groups which work closely with other licensed groups. For example, respiratory care practitioners work solely from a physician order; therefore, the State Department of Minnesota recommended that registration would be the most appropriate form of regulation (Tom Hiendlmayr, telephone interview, May 1991).

When an occupational group is registered by the State, a separate licensing board is usually not authorized. The responsibility for the implementation of statutes pertaining to registration may be placed with an existing licensing board or may be implemented by the Minnesota State Health Department. In the case of the respiratory care practitioners, they will be placed under the authority of the Board of Medical Examiners due to their close working relationship with physicians.

In the State of Minnesota, the following health care occupations require registration:

Audiologist
Contact Lens Technician*
Dental Assistant
Emergency Medical Technician
Hearing Instrument Dispenser*
Occupational Therapist*
Occupational Assistant*
Physical Therapist
Physician Assistant
Respiratory Care Practitioner*
Speech Language Pathologist*

* Newly regulated as of 1991 (see appendix A, page 78).

The advantage of registration is that it is less costly since a separate board is usually not formed and it is less restrictive while protecting the public by requiring entry level education requirement and MCE for renewal. The disadvantage is that it does not prevent other practitioners from performing the duties of the registered group.

Licensure

Licensure is defined in Minnesota Rule 4695.0600 subpart 16 as "a system whereby a practitioner must receive recognition by the state that he/she has met predetermined qualifications, and persons not so licensed are prohibited from practicing." This provides title and scope of practice protection.

The U.S. Department of Health, Education, and Welfare (1977) defined licensing as the "process by which an agency of government grants permission to an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected" (Shimberg 1980). Licensure is considered the most restrictive form of legal regulation. Licensing laws are often referred to as practice acts and contain the defined scope of practice for a particular occupation. This requires anyone performing these duties to be licensed by the state.

The licensure mechanism has resulted in increased social costs. These social costs include: excessive restriction on entry into the profession, difficulty in developing innovations in the distribution of medical care, and severe limitations to the activities of nonmedical health practitioners who pose a competitive threat to the physician (Rayack 1983).

In addition, the more restriction in the licensure act, the higher the costs of regulation. Gaumer (1984) reviewed the literature regarding regulating health professionals and reported evidence that restrictions affect location patterns and supply of professionals and that a correlation exists between strict use of reciprocity agreements and higher incomes for health professionals.

In addition, if continuing education is mandatory, the cost of licensing further escalates. In a 1982 report, the annual cost of continuing education courses in health sciences was projected to be $60,703,710 in the state of California (California State Postsecondary Education Commission 1982). This report estimates the annual costs to licensees of 15 health science occupations and ranged from $42 to $650 per year.

Licensure in Minnesota is considered only for those occupations which practice independently and have the potential for causing harm to the public. In Minnesota, the following 14 health care occupations are licensed (see appendix A, page 78):

Chiropractor
Dentist
Dental Hygienist
Marriage and Family Therapist
Medical Doctor
Nurse, Registered
Nurse, Practical
Nursing Home Administrator
Optometrist
Osteopath
Pharmacist
Podiatrist
Psychologist
Social Worker

Mandatory Continuing Education

Early History

Mandatory continuing education gained acceptance after a report from the President's Commission on Health Manpower in 1967 (O'Reilly 1982). It was this report that identified how the major changes in technology occurring in health care could lead to obsolescence of competence for current practitioners. As a result of this report and a follow-up report in 1971 by the U.S. Department of Health, Education and Welfare, the

voluntary approach to continuing education began to be questioned by professional groups (Shimberg 1980). It was this 1971 report that triggered the movement toward mandatory continuing education for relicensure or recredentialing. Thus, professional associations, state licensing boards, and specialty boards (e.g., American Board of Family Practice) began to require MCE for membership, relicensure, and recertification.

Continuing medical education (CME) has changed greatly since the beginning of the century. In the early 1900s, CME was a form of remedial education to make up for gaps in previous formal education programs. By the 1930s, CME was considered necessary for physicians to remain updated on the advances in health care technology. Moreover, physicians trained during World War II had less training. During the 1950s, most CME was offered by academic institutions and included formal lectures. Participation in CME by physicians was regarded as a responsibility of a professional. This was demonstrated by the increase in attendance between 1962 and 1975. During this thirteen year period, the number of registrants for American Medical Association approved courses rose from 71,000 to 354,000 per year (O'Reilly, 1982).

During the 1970s, many health care state licensing boards and professional associations implemented mandatory continuing education requirements. In 1971, New Mexico was the first state to pass MCE for physicians as a part of relicensure requiring 120 hours of instruction every three years. The first medical specialty board to require MCE was the American Board of Family Practice (ABFP) (O'Reilly 1982). The ABFP required 150 hours every three years to maintain membership. By 1988, twenty-eight states and territories had MCE requirements for renewal of the license to practice medicine (Osteen and Gannon 1988).

Philosophical Debate Over MCE

The philosophical arguments over MCE are present in the literature. The main argument in favor of MCE is that professions need continuing education to prevent

obsolescence. Houle (1980) reports that regardless of the occupation, active practitioners can be divided into four general groups: laggards, middle majority, pacesetters, and innovators. Houle suggests "that laggards do not respond properly to their privileged position. Their ideas have hardened; their old skills deteriorate and they adopt few new ones, usually by a complex process of osmosis or by yielding to pressure." It is the first group, the laggards for which mandatory continuing education is focused.

In the late 1960s and early 1970s, "accountability" became a key concern of consumers with the leadership of Ralph Nader (Rockhill 1983). The public wanted protection from incompetent professionals. Mattran (Kreitlow 1983) suggests that when an individual enters a chosen occupation which is licensed he/she has chosen to follow the practices of the occupation. Therefore "the question of mandated continuing education's violating individual freedom is not really an issue" (Mattran 1983).

The idea that mandatory continuing education is a treatment for performance deficiencies underlies the trend toward MCE (Darkenwald and Merriam 1982). Darkenwald and Merriam (1981) suggest that education is not a panacea for social problems and that dealing with problems effectively requires recognition of the real causes. Rockhill (Kreitlow 1983) points out that:

> The only mandated performance criterion is participation.....That education may only partially contribute to competence, and that competence may be only one component in accountability, does not matter; a mandatory education policy assumes that accountability is dependent on education.

And, finally, Ohliger (1981) reports that there is no evidence that MCE guarantees learning; it may undermine it. Whether continuing education was mandated or voluntary had no effect on participation of practitioners in education activities as reported by two studies. Osborne (1988) surveyed physicians and sponsors after the repeal of the MCE requirement in Illinois. Most physicians and sponsors believed that there was no effect on attendance at continuing education activities after the repeal of MCE. Another study which

surveyed 151 internists and 240 family physicians revealed no major change in education activity by physicians as a result of regulations (Stross and Harlan 1987).

The Question of Effectiveness

There is much literature scrutinizing the effectiveness of MCE. A review of the studies of the effectiveness of continuing education in the health occupations reports that maintenance of professional competency has never been clearly and consistently demonstrated (Young and Willie 1984). Dowling (1985) conducted a mail survey of 1,901 dental hygienists in Wisconsin and Minnesota to determine the impact of mandatory versus voluntary continuing education systems for relicensure on performance. An analysis of the data demonstrated no practical significant difference in performance between the study populations practicing under mandatory and under voluntary continuing education systems. In an analysis of MCE for physicians and lawyers, the author points out that although mandatory continuing education had a positive effect on the knowledge level of medical practitioners, effects on performance are limited and impact on quality of care was unproven (Frye 1990).

The failure of MCE to accomplish its intended goals is due in part to the practices of licensing boards and to the difficulty in defining and measuring competency. Phillips (1987) cites perceptions and practices of licensing boards as the major weaknesses that hinder MCE from becoming a stronger force in relicensure and performance.

However, there is evidence to support MCE as a relicensure requirement. Beaudry (1989) reviewed over 300 articles relating to MCE with only 41 articles meeting his criteria for research design. The research criteria included: studies must include a comparison group in research design, studies with only pre and post test designs were excluded, and studies had to have sufficient statistical analysis to apply techniques for size calculation. The overall conclusion was that MCE had positive outcomes in relation to physician knowledge and performance and patient health status.

There is other evidence which suggests that MCE does promote positive outcomes. Richards and Cohen summarized 36 studies that assessed changes in the performance of physicians or in patient outcomes and found a positive impact as a result of MCE (Phillips 1987). A study which compared the continuing education attendance patterns of registered nurses in Indiana in 1975 and 1978 indicated that the least educationally prepared nurse was the least likely to attend continuing education (Puetz 1983). As a result of this study Indiana did pass regulations for nursing which included MCE.

Mandatory continuing education has also encouraged employers and educational institutions to offer more courses. In a study which reviewed research projects investigating mandatory continuing education in Florida indicated that MCE had enhanced opportunities for nurses' professional growth and development (Jahns 1986).

Finally, MCE has provided an incentive for professionals to seek continuing education; there has been an increase in the number of courses available for professionals. MCE has created more opportunities from which individuals can choose and has encouraged employers to provide continuing education.

Requirements for Mandatory Continuing Education in the Health Occupations

The reporting frequency and amount of MCE required and the procedures for implementing MCE in the health care professions are difficult to review. If this information is reported it is usually reported as part of a study reviewing effectiveness of MCE by a particular occupational group. Phillips (1987) reported the trends and status of MCE in the United States. According to this study, the six states with the highest continuing education requirements were California, Iowa, Kansas, Minnesota, Nevada, and New Mexico; the states with the lowest were Hawaii, New York, and Wisconsin.

There were no studies published by licensing boards; however, this information may be available through other state government reports. The most recent report from the

Minnesota State Advisory Council was a 1981 report which only listed hours, reporting cycles, and fees but not practices or procedures and this information was already dated.

Number of Hours Required and the Renewal Cycle

The number of hours required and the renewal cycle varies greatly among occupations as well as from state to state. The Florida Physical Therapy Association, Inc. surveyed nine health related associations about the MCE requirements for relicensure (Finley 1988). Six of these occupations implemented MCE due to pressure form the State legislature; three occupations implemented MCE because members were requesting continuing education for maintenance of knowledge and skills. The number of hours required ranged from 10 to 50 contact hours every year. Most associations had a two or three year cycle for renewing licenses.

A survey of physical therapists in southeastern United States indicated that they preferred ten hours per year and a three year cycle period (Gardner, Seymour, and Lacefield 1981). In Michigan, physicians are required to show evidence of participation in 150 hours of CME activities every three years (Stross and DeKornfeld 1990).

A study which reviews California (1989) state licensing and continuing education requirements was similar to the present study. This study reviewed 30 occupations which included the following health care professions: chiropractor, counselor (Marriage and Family and Child), dental assistant, dental hygienist, dentist, nurse (anesthetist, licensed practical, midwife, public health, registered), optometrist, pharmacist, physicians-osteopathic, physicians and surgeons, podiatrists, respiratory therapist, and social worker. Table 1 summarizes MCE requirements for the health care occupations in the state of California which required continuing education for renewal as of January 1989.

In summary, the number of MCE hours required ranged from 7.5 per year for a respiratory therapist to 50 hours per year for Osteopathic Physicians. The mean hours per year for this group of 12 occupations was 19.9 hours per year. The most common cycle time to renew licenses was two years.

Table 1.--Hours Required Per Renewal Cycle in California

Occupation	Hours	Renewal cycle Year/s
Chiropractor	12	1
Counselor (Marriage and Family and Child)	unclear	2 years
Dental Assistant	25	2
Dental Hygienist	25	2
Dentist	50	2
Nurse	30	2
Optometrist	20	1
Pharmacist	30	2
Physician - osteopathic	50	1
Physician and surgeon	25	1
Respiratory Therapist	15	2
Social Work	unclear	2

Types of Activities

The types of educational activities which licensing boards would accept as credit were mentioned intermittently in the studies reviewed. There were no studies by licensing boards. Most studies were done by occupational groups or professional associations reviewing practitioner preferences or behaviors. The articles reviewed suggest that the most common activity was the lecture or workshop type activity.

A study in Michigan (Stross and DeKornfeld 1990) reported that lectures or workshops were most commonly attended by physicians. This study was a formal audit of continuing medical education activities of physicians done to assess compliance with a law mandating 150 hours of continuing education every three years (75 hours in category 1).

Category 1 hours were obtained by attendance at a board approved activity. Any course planned, sponsored, or cosponsored by a medical or osteopathic medical school, state or national medical or osteopathic association, or a national medical specialty society would be presumed to meet the criteria for category 1. The average physician participated in 175 hours of category I approved activities and only five practitioners (0.01%) had less than the minimum of 75 hours.

This study also reported the mean hours of self-directed learning which physicians reported. Examples of these self-directed learning activities and the mean number of hours documented over three years were: teaching medical students-28.2 hours, publishing textbooks-18.6, self-assessment-13.5, and self-instruction (reading)-16.1 (Stross and DeKornfeld 1990).

There were studies which reported the effectiveness of self-directed learning activities. DeMuth (1983) studied pharmacists using independent study of professional journal articles to fulfill mandatory continuing education requirements. The results of this study revealed that this was a satisfactory method of independent study. It was not clear how many pharmacists sought continuing education through self-directed learning activities.

Evaluation

Few studies describe the evaluation mechanism for continuing education that was required by licensing boards; however, several studies suggested that evaluation mechanisms were not effective in determining outcomes. One study (Hogan 1983) mentions how the satisfaction scale lost credibility after Naftulin and associates (1973), in "The Doctor Fox Lecture", revealed the inadequacies of the satisfaction scales frequently used to evaluate education programs. This study programmed an actor to teach charismatically and nonsubstantively on a topic about which he knew nothing. Fifty-five subjects responded favorably at the significant level to an eight item questionnaire concerning their attitudes toward the lecture. The authors concluded "that emphasizing

student satisfaction with learning may represent little more than the illusion of have learned."

In Finley's (1988) review of nine related health occupations, there was brief mention of the use of post tests. He reported that two of the nine occupations required post tests for MCE but mechanisms for retake of tests were not available if a participant failed. It was not clear how those cases were resolved.

Program Approval and Providers

Licensing boards may require preapproval of programs submitted for MCE. The mechanisms for approval of required continuing education hours is determined by each licensing board and these practices are not standardized. Licensing boards may approve courses on an individual basis, through a sponsor or through a provider. The terms "provider" and "sponsor" are often used interchangeably. Here, the term "sponsor" refers to an organization or group which has approval to offer one specific course. "Provider" refers to a group or organization which has been approved by a licensing board to offer many courses over an approved time frame. When providers are approved, they have demonstrated that their courses meet the licensing board's course requirements.

This approval for providers is usually granted for one to six years. In the California study (1989), one occupation approved providers for one year and four occupations approved providers for two years. The California Medical Association (CMA) approved providers for one, two or four years. The CMA application fees were $350 for non-hospital providers and $550 for hospitals plus a $100 annual renewal fee. The Accreditation Council for Continuing Medical Education (ACCME) approves courses taught nationwide and approves providers for two, four or six years The ACCME fees were $2500 for the initial fee and $1600 for the renewal fee every two years.

Most of the state boards in California (University of California Extension 1989) have a mechanism for provider approval. Only two California boards will approve individual programs. There was no mention of audits in the California Extension study

(1989) which suggests that if all courses are provided by the approved providers there would then be no need for audits. When program approval is not required, licensing boards will audit licensees to verify completion of MCE requirements.

The attitude of professionals toward program approval is generally positive. Physical Therapy practitioners were surveyed and 80% of the practitioners indicated that courses should be reviewed for approval (Gardner 1981). The preferred approvers and providers for this group were: District/state offices of American Physical Therapy Association (APTA), employers, academic institutions, state licensing boards, national APTA, and individuals with specialties.

The most common providers of CME in a Michigan study of physicians showed that 53.1% of the continuing education hours were obtained through medical schools or at a national meeting, and only 27.6% of the hours were obtained in hospital sponsored courses in the area where the physician resided (Stross and DeKornfeld 1990).

Documentation

The documentation consists of three types. One type of documentation is required when an individual or sponsor is requesting approval of a specific course. Providers who are approved to offer courses do not have to submit documentation for each course. The second type of documentation required is evidence of completion of the continuing education activity. This documentation may be a certificate of completion or a canceled check (if preapproved). The third type of documentation is required by licensing boards who audit practitioners to verify completion of MCE. The documentation for audits varies; one licensing board require documentation such as an outline, objectives, instructor qualifications and an evaluation mechanism and the other licensing board required only a certificate of attendance or canceled check.

There were no studies that identified and compared the documentation required for program approval or for providers. Each licensing board determines how much and what kind of documentation will be required for approving individual courses and organizations

who request to be providers. These procedures were not specifically described in the rules or in the literature.

There was one study which reviewed the documentation practices of physicians in Michigan. In this study, only 266 of 967 (28%) forms audited accurately documented the number of hours claimed (Stross and DeKornfeld 1990). Some of the problems with documentation encountered during this audit were: listing of the same activity in several categories; requesting educational credit for an association's recognition award; failing to submit documentation of course attendance; submitting airline tickets and hotel receipts as evidence that a course was attended without any formal certification of attendance; documenting hospital conference participation; and making addition errors on over 50% of the forms submitted (Stross and DeKornfeld 1990).

Enforcement

A review of the literature provided no articles which mentioned enforcement procedures or the number of practitioners who failed to comply with the MCE requirement and therefore lost their licenses. However, there is literature suggesting that the enforcement of the licensure renewal requirements by licensing boards in general is lacking. In 1971, the Department of Health, Education, and Welfare reported that disciplinary action by medical boards was low compared to the number of practicing physicians; this implied lenient practices by licensing boards (Hogan 1983).

The low number of disciplinary actions is striking. Between 1963 through 1967, using files of the Federation of State Medical Boards, it was revealed that only 161 license suspensions and 334 revocations occurred out of some one quarter million physicians (Hogan 1983). Hogan (1983) suggests that some of the reasons why licensing boards have been ineffective in enforcing the law include: lack of adequate funding, inadequate professional staff, vagueness and lack of specificity in the disciplinary provisions of the law itself, and the tendency of licensing boards to wait for the public to report disciplinary problems.

Alternatives to Mandatory Continuing Education

Some occupations are considering reexamination for relicensure in lieu of MCE. However, most practitioners are resistant to reexamination. A regional survey of physical therapists in the southeastern United States indicated that 67% of the respondents preferred continuing education rather than reexamination. There were 17% of the respondents who favored reexamination on a five-year cycle with self assessment prior to the examination (Gardner, Seymour, and Lacefield 1981).

In Finley's (1988) survey of related health associations in Florida, two associations stated that they were considering using an examination for relicensure in lieu of MCE. One association stated that self-assessment examinations were being explored.

Summary

In summary, the literature written about the licensing of practitioners and mandatory continuing education is vast. Studies have been done in fields such as law, social sciences, health care occupations, and education. The licensing of health professionals is not new but the number of occupations seeking licensure is increasing; as health care costs rise, there is a need to evaluate the social costs of licensing health care professionals.

The philosophical debate regarding the effectiveness of mandatory continuing education is extensive in the literature. Many studies report that MCE overall is beneficial but these studies have not shown how MCE maintains competence. It has been suggested the MCE is useful as an incentive for the laggards of a profession to seek educational activities but there is also evidence that MCE has had little effect on participation.

The periods for renewing licenses varied greatly among the occupations. The hours per year required ranged from 7.5 to 50 hours per year. The modal education cycle was two years for the California study and two to three years in Florida.

Program/provider approval was required among health occupations in California but the practices were not described. A report of a formal audit indicated that most

physicians attended seminars and workshops and that the documentation was inconsistent and inaccurate.

Evaluation and enforcement of MCE by licensing boards of health care occupations was mentioned briefly or was not reported in the studies reviewed. However, it was reported that satisfaction scales frequently used have not provided evidence that learning has occurred and that enforcement practices by licensing boards have been lacking.

CHAPTER 3

METHODOLOGY

This chapter presents a summary of the criteria used to select the health occupations to study and the process of selecting the individuals to be interviewed. The development of the interview questions and a data summary sheet will be described. The data collection process will be reviewed along with the procedures for analyzing the data. Finally, the limitations of the study will be discussed.

Selection of Health Occupations to Study

During the 1980s, there has been increasing public awareness of the inadequacies of the competencies of physicians and other health care practitioners. Previously, the general public seldom questioned the doctors' practices or decisions. The health care industry is now under close scrutiny as legislators try to control the escalating costs of health care and protect the public from harm. Mandatory continuing education has been used by legislators as one method to maintain continued competence of practitioners. Therefore, this study was designed to focus on the MCE component of the regulations which relate to the health occupations.

Criteria

In order to select the health care occupations to study, characteristics common to legislated health care occupations were identified. This led to identifying the criteria for selecting the health care occupations for the study. The following criteria were identified:

1. The occupation must be legally recognized in Minnesota either through licensure or registration.
2. The professional practitioner has direct involvement with patient/client care (mental as well as physical).
3. Continuing education is required for renewal of the license or registration.
4. The occupation is regulated by a state licensing board.

Practitioners in nonregulated fields such as radiology technician and dietitian may or may not be routinely involved in continuing education and their activities would be difficult and costly to survey. Therefore, regulated health care occupations with MCE as a renewal requirement were identified as important criteria. For the purposes of this study, health care occupations involved in direct (mental or physical) patient care were studied although there are many occupations involved in health care delivery. The authority for implementing the state regulations is usually the responsibility of a licensing board; therefore, regulation by a state licensing board was identified as a fourth criterion. All of the criteria that were selected will facilitate comparisons of MCE in health occupations within Minnesota and among other states.

The health care industry has developed into many paramedical specialties and includes a vast number of practitioners from acupuncturists to interpreters. A definition of a health care profession was needed to delimit the study; thus, a health care profession was defined as one involved in direct patient/client care (mental as well as physical).

Procedures

A list of state licensing boards for the health care occupations was obtained through the Minnesota Department of Health (see appendix B, page 80). From this list, the Minnesota statutes and/or rules for these licensing boards were examined and a list of regulated health occupations was compiled. The list included the following 17 occupations/groups related to health care provision:

1. chiropractor
2. dental assistant
3. dental hygienist
4. dentist
5. marriage and family therapy
6. midwifery
7. nurse
8. nursing home administrator

9. optometry
10. pharmacy
11. physical therapy
12. physician assistant
13. physician and surgeon, osteopath
14. podiatry
15. psychology
16. social work
17. unlicensed mental health practitioner

Three of the above occupations—dental assistant, physical therapist, physician assistant—are regulated by registration, one a permit-unlicensed mental health practitioners, and the remaining 13 are licensed. The Board of Unlicensed Mental Health Practitioners issues permits to mental health workers otherwise noncredentialed.

Four of the 17 occupations failed to meet all four of the selection criteria. Licensed psychologists were excluded because they have no continuing education requirement as part of their licensure renewal process. Midwifery was excluded since there have been no applications for midwifery in forty-five years and no one is licensed in the state of Minnesota. Nursing home administrators were excluded since they do not have a direct patient/client involvement. Mental health practitioners were neither licensed nor registered (permits issued) and did not require continuing education for renewal and therefore were excluded. The remaining 13 occupations met all four criteria and were selected for study. They were:

1. chiropractor
2. dental assistant
3. dental hygienist
4. dentist
5. marriage and family therapy
6. nurse
7. optometry
8. pharmacy

9. physical therapy
10. physician assistant
11. physician and surgeon, osteopath
12. podiatry
13. social work

Note this list was generated from health care occupations regulated through licensing boards not those regulated through the Minnesota State Department of Health. Veterinarian was excluded since it is not a human health care occupation and Harmful Substance Compensation is not a distinct health care occupation.

Selection of Individuals to be Interviewed

The enforcement of the rules for these 13 health care occupations is the responsibility of the nine state boards. The executive directors of these state boards were targeted to be interviewed. These individuals are involved in seeking legislative directives and in monitoring the day-to-day operations of the licensing boards. For these reasons, the executive directors were contacted by telephone to invite them to participate in this study.

A brief description of who was conducting the study and the purpose of the study was provided at the time of this initial telephone contact. Five of the executive directors agreed to be interviewed in person. One executive director consented only to participate in a telephone interview. Two executive directors identified staff who were responsible for continuing education and one executive director nominated an assistant director to participate in the interview.

Instruments

Data Summary Sheet

A data summary sheet was developed to collect information from published sources for each profession. The sections of the data summary sheet were identified after an initial review of the rules and/or statutes. The four sections on the data summary sheet were as

follows: type of regulation, initial licensure/registration requirements, renewal requirements and enforcement. A copy of the data summary sheet is included in appendix C, page 82

The state statutes were used to obtain a definition of the practitioners who were being regulated and the type of regulation involved (i.e., licensure or registration). The rules provided details about the process for the implementation of the statutes.

Interview Schedule

After the data summary sheets were completed, the interview questions were proposed. The goals of the interview schedule were twofold: to confirm the accuracy of information obtained from the statutes and the rules, and to obtain information about the continuing education renewal requirements, documentation, and enforcement practices.

Therefore, the first part of the interview schedule was designed to allow the interviewer to refer to the data summary sheet for clarification and confirmation of key points. The second part of the interview requested information about renewal requirements, program approval mechanisms, documentation required, and how often disciplinary action was taken. The questions were designed to elicit both factual information and expert opinion from the executive directors.

It is characteristic for the statutes to give general directions for the regulations and for the rules to provide specific details for implementation by the board. For example, the rules may state that a national or state examination will be given as part of the initial requirements for licensure or that a clinical examination may be given for the same purpose at the discretion of the board. The actual procedures may not be determined clearly from reading the rules. This ambiguity generated questions to investigate in more detail such as "Who approves programs?" and "What documentation is required"?

The interview schedule went through four revisions; two professors of adult education helped by reacting to the proposed items and format of the instrument. The schedule was pretested with one individual. This individual was a former member of the Health Services Occupations Advisory Council which in Minnesota reviews requests for

legal credentialing from health care occupations and makes recommendations to the Commissioner of Health (see appendix D page 84, for copy of interview schedule). The interview questions were then submitted to the Committee on the Use of Human Subjects in Research and approved (see appendix E, page 89, for approval letter).

Data Collection

The eight personal interviews and one telephone interview with an executive director or his or her designee took place the latter part of April and first part of May, 1991. A consent was obtained from each interviewee (see appendix F, page 91, for example of consent form). The interviews lasted between forty-five minutes and one hour. Written notes were taken during the interview. Some of this information was added directly to the data summary sheets. In addition, some executive directors provided written rules or updates on the current rules for their occupations. After recording information on the data summary sheet, nine telephone calls were necessary to clarify or solicit information obtained or not obtained during the interview.

Data Analysis

A content analysis of the state rules and statutes was completed on separate data summary sheets for each of the 13 occupations. Written documents provided by licensing boards were also examined and results recorded on the data summary sheets. During the interview, executive directors or their designee were asked to verify the content of the data summary sheets and changes were made as needed. The responses to the interview questions were also recorded on the data summary sheet to complete the summary of the practices used to regulate the occupation. Tables were developed to summarize the responses of each occupation to the study questions.

Limitations of Study

One limitation of the study was the selection of the individuals to be interviewed. The executive director of each board was selected as the person most knowledgeable about relicensure requirements. However, if the board has several staff members, the executive director might not be familiar with all components of the licensure process. In these boards with two or more staff members, the continuing education requirements were usually monitored by other staff members. Also, the executive directors of state boards which regulated more than one occupation may not be familiar with each occupation's requirements and disciplinary activities.

Another limitation is that this information is limited to one state. Because licensure renewal involves a state function, the types and amounts of requirements for licensure renewal vary from state to state. The MCE required by Minnesota state boards may differ from other states.

Lastly, the data collected can be quickly dated. Some occupations were in the process of change when they were being studied. For example, although no legislation had been passed, the Board of Marriage and Family Therapy plans to change their cycle from one year to every two years. In addition, more occupations are being regulated (i.e., within the next two years the occupations of Hearing Instrument Dispensers, Occupational Therapy, Optical Technicians, Physical Therapy, Respiratory Care, and Speech Language Pathologists and Audiologists will be legally recognized and regulated by the state of Minnesota).

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

This chapter will describe the type of regulations concerning initial licensure/registration and license/registration renewal for 13 health care professions which are regulated through licensing boards in the state of Minnesota. The initial requirements for the amount of education, experience and examinations which are required for entry into the regulated field will be summarized. The continuing education requirements for renewal will be reviewed. This review of the renewal requirements will include a summary of the number of instruction hours per cycle [time period], the types of education activities which meet the MCE requirement, the program and provider approval and auditing processes, the documentation of the MCE, and the enforcement practices of the licensing boards. Finally, the opinions of executive directors of licensing boards about benefits and disadvantages of mandatory continuing education will be reported.

Types of Regulations

Of the 13 health care occupations reviewed, licensure was the form of regulation for ten health care occupations in the state of Minnesota. Only three occupations—physical therapy, physician assistants, and dental assistants—were regulated by registration.

The actual restrictions which occur within the licensure/registration acts varied considerably. For example, no individual may perform the duties of a physician unless under the supervision of the physician (physician assistants can prescribe medications if delegated by their supervising physician). At the other end of the restriction scale, many occupations can perform duties similar to a social worker but are not required to hold a license as a social worker. A nurse who coordinates discharge planning usually is not a licensed social worker but his/her title is discharge planner. Counselors also have duties which could be defined as social work (e.g., treatment interventions to facilitate social

needs). However, as long as they do not use the title social worker, they do not need to hold a social worker license. This illustrates how some licensure acts may be closer to title protection rather than the restriction of practice.

Overall, the scope of practice which describes the general duties/functions of an occupational group is written in vague terminology to allow for changes in job duties related to changes in technology or procedures. However, this creates ambiguity when one tries to list specific duties performed by an occupation. This results in some occupations performing duties considered a part of another occupation. For example, respiratory care practitioners in some hospitals assist in hemodynamic monitoring which, in most hospitals, is a nursing function.

More recently, Minnesota has used registration for occupations when title protection is identified as the best form of regulation. An exception to this rule is physical therapy. Physical Therapy was registered many years ago and the mechanisms of the registration act is closer to a licensure act. In practice, there are no other groups which perform the duties of a physical therapist so, although the regulation is registration, it does restrict the practice to physical therapists.

The regulations of nurses are probably the most complex since nurses are required to be both registered and licensed in the state of Minnesota in order to practice. No other state has a similar requirement (Board, personal interview, April 1991). Nurses must first become licensed through an examination process and then they must maintain a current registration for practice; only the registration must be renewed. Mandatory continuing education is required for registration renewal. The individual interviewed was unable to explain how this dual type of regulation evolved.

The previous examples serve to illustrate that although there are two different types of regulation each with a specific function, there has not been any consistency in selecting the type of regulation for the occupations studied. See table 2 for a listing of occupations, their type of regulation, and the year the licensing board was established in Minnesota.

The last column of table 2 refers to the restrictiveness of the regulation. The restrictiveness of the occupations is the opinion of the investigator after interviewing representatives from these regulatory boards.

Table 2.--Type and Restrictiveness of Regulations of Health Occupations

Occupation	Type of regulation	Year Regulated	Restricts Practice
Optometrist	License	1915	Yes
Podiatry	License	1917	Yes
Chiropractor	License	1919	Yes
Physicians and Surgeon	License	1921	Yes
Pharmacist	License	1936	Yes
Registered Nurse	License/Regist.	1945	Yes
Physical Therapy	Registration	1955	Yes
Dental Assistant	Registration	1969	No
Dental Hygienist	License	1969	Yes
Dentist	License	1969	Yes
Physician Assistant	Registration	1976	No
Marriage and Family Therapy	License	1987	No
Social Work	License	1987	No

The early occupations which were licensed were well established occupations and their scope of practice is well defined. The number of allied health care occupations has increased over the last thirty years. These occupations tend to duplicate duties of other allied health occupations; therefore, in practice, it is more difficult to restrict other groups from all of the duties performed by one occupation. Also, when the scope of practice was

written for the statute, it was deliberately kept vague to allow for new procedures or services to be offered by the regulated group.

Each occupation may not have a separate state board. Two governing boards were the regulatory authority for two or more occupations. Except for nursing and dental hygiene, it was the registered occupations (e.g., dental assistant, physical therapy, and physician assistant) that were regulated by a related licensing board. Nursing is both registered and licensed and is regulated by a Board of Nursing. Dental hygiene although licensed was regulated by the Board of Dentistry which also regulates dental assistants and dentists. See table 3 for a summary of occupations and their governing boards.

Initial Requirements for Regulation

Schooling Requirements

All of the occupations reviewed required graduation from accredited colleges or programs for initial licensure or registration. This accreditation was usually a national accrediting body for that particular occupation; the only exception to this national accreditation was nursing. The Minnesota State Board of Nursing accredits all nursing programs in the state. Currently they have accredited 23 professional nurse (Registered Nurse) programs. This was the only state board, which regulated health care occupations in Minnesota, that was involved in accrediting preservice education programs. See table 4 for the summary of schooling requirements for initial licensure/registration.

The minimum amount of schooling required for the initial licensure/registration varied between nine months (dental assistants) to graduate work (social work) to professional doctorate degrees (physicians). The modal amount of schooling was a baccalaureate degree (n=7) (see table 4).

Table 3.--Governing Boards for Health Care Occupations

Occupation	Governing Board
Chiropractor	Board of Chiropractor Examiners
Dental Assistant	Board of Dentistry
Dental Hygienist	Board of Dentistry
Dentist	Board of Dentistry
Marriage and Family Therapy	Board of Marriage and Family Therapy
Nurse - Professional (RN)	Board of Nursing
Optometry	Board of Optometry
Pharmacy	Board of Pharmacy
Physical Therapy	Board of Medical Examiners
Physician Assistant	Board of Medical Examiners
Physician and Surgeon, Osteopath	Board of Medical Examiners
Podiatry	Board of Podiatry
Social Work	Board of Social Work

Examination Requirements

All of the 13 health care occupations required at least one or more written tests for initial licensure/registration. Ten of the written tests have been developed by national testing organizations or professional organizations. There are regional or state developed tests given by the optometry, dentistry, pharmacy and chiropractor boards. The State Board of Family and Marriage Therapy also administers an oral examination which it developed. See table 5 for a summary of the examinations required for initial licensure/registration.

Table 4.--Schooling Required for Entry to Regulated Health Occupations

Occupation	Minimum Schooling Requirements
Chiropractor	Baccalaureate degree from college accredited by the Council on Chiropractic Education.
Dental Assistant	9 - 12 months program accredited by the American Dental Association (ADA).
Dental Hygienist	Associate or baccalaureate degree from program accredited by ADA.
Dentist	Baccalaureate degree from program from program accredited by the ADA.
Marriage and Family Therapy	Masters degree in marriage and family therapy from program accredited by the American Association for Marriage and Family Therapy.
Nurse-Professional (RN)	Associate or baccalaureate degree from program approved by the State Board of Nursing.
Optometry	Baccalaureate degree from program accredited by the American Optometry Association.
Pharmacy	Baccalaureate or Doctor of Pharmacy from program accredited by the Council on Pharmacy Education.
Physical Therapy	Baccalaureate degree from program accredited by the American Physical Therapy Association.
Physician Assistant	Completion of Physician Assistant training program accredited through the National Physician Assistant Association.
Physician and Surgeon, Osteopath	Doctor of Medicine or Osteopathy accredited by a committee of the American Medical Association.
Podiatry	Baccalaureate degree from program accredited by the Council on Podiatry Medical Education.
Social Work	Baccalaureate degree or Masters degree in social work, depends on level of license. Accredited by the Council on Social Work Education.

In addition, four occupations (dental hygiene, dentist, optometry, and pharmacy) require a clinical examination. The clinical examinations for dentists and optometry

performed on patients. The pharmacy practical or clinical examination is administered in a laboratory which simulates a pharmacy.

Table 5.--Examinations Required for Initial License/Registration

OCCUPATION	TESTING / EXAMINATIONS
Chiropractor	Written examination and oral examination written by the state board. Completion of national examination is usually before graduation.
Dental Assistant	Written examination developed by the State Board of Dentistry.
Dental Hygienist	Written examination by the American Dental Association (ADA) and the clinical examination is the Central Regional Examination.
Dentist	Written examination by the ADA. Clinical examination performed on patients (Central Regional Examination).
Marriage and Family Therapy (MFT)	Written examination by the National Board of MFT Examiners. Oral exam given by the State Board of Marriage and Family Therapy.
Nurse-Registered	Written examination by the National Council of State Board of Nursing, Inc.
Optometry	Written examination by the National Board of Examining Optometrists. Minnesota examinations include the optometric jurisprudence test and a clinical demonstration examination.
Pharmacy	Written examination by National Board of Pharmacy Federation of Licensure Examinations. Minnesota written and practical (or clinical) examination and the Federal Drug Review examination.
Physical Therapy	Written examination developed by the National Board of Physical Therapy.
Physicians Assistant	Written examination from the National Commissions on Certification of Physician Assistants.
Physician and Surgeon, Osteopath	Written examination by National Board of Medical Examiners, part 1, 2 and 3 and Federation Licensing Examination; cooperative examination given by the State.
Podiatry	Written examination from the National Board of Podiatric Medical Licensing Examination.
Social Work	Written examination by the American Association of State Social Work Boards.

Physicians, podiatrists, social workers, marriage and family therapists, and pharmacists are the only health care personnel required to complete internships or work experience prior to application for license. In pharmacy, some of the hours required for the internship are completed during the degree program itself.

Renewal Requirements

None of the original statutes for health occupations regulated prior to 1970 included continuing education requirements for renewal. However, all of these occupations added continuing education in the 1970s after or just before statute Chapter 214—Examining and Licensing Boards—was passed by the state legislature in 1976. This statute describes criteria for regulation and implementation guidelines for regulations to be used by the legislature. In addition, Chapter 214.12 gave licensing boards the authority to promulgate rule requirements for continuing education to promote licensee competence as a part of licensure renewal. Licensing boards which regulated more than one occupation utilized the same renewal process for all the occupations they regulated.

Reporting Period

Each occupation establishes a continuing education cycle or period of time for practitioners to report proof of attendance at continuing education events. The modal cycle was two years representing seven out of 13 occupations reviewed. The longest cycle was five years required by the State Board of Dentistry for the three dental occupations and the shortest cycle was one year required by the Boards of Podiatry and Family and Marriage Therapy. See table 6 for the number of years in the reporting period for each occupation.

Table 6.--Hours, Reporting Cycle and Fees Required for Renewal of License or Registration

Occupation	No. of Licensees	Hours per Cycle	Reporting Cycle Year/s	Fee per Year $
Chiropractor	Total: 1500 Active: 1300	40	2	100
Dental Assistant	Total: 4082 Active: 3351	25	5	17
Dental Hygienist	Total: 2785 Active: 1985	40	5	25
Dentist	Total: 3939	75	5	70
Nurse -Registered	Total: 119,931 Active: 48,000	30	2	32 *
Marriage and Family Therapy	Total: 731	15	1	100
Optometry	Total: 783 Active: 595	45	3	90
Pharmacy	Total: 3400	30	2	65
Physical Therapy	Total: 2800	20	2	20
Physician Assistant	Total: 120	50	2	40
Physician and Surgeon, Osteopath	Total: 9500	75	3	115
Podiatry	Total 120	15	1	225
Social Work	Total: 9300	30	2	60 to 150*

* Occupations with biennial fee schedule.

Minimum Hours Required

When the hours are averaged by year, the number varied from five continuing education hours per year for dental assistants to 25 hours per year for physicians and physician assistants. The continuing education hour was defined as 60 minutes of an

uninterrupted planned educational activity for ten of the 13 occupations reviewed. Only three occupations—Marriage and Family Therapy, Nursing, and Social Work—would accept 50 minutes. See table 6 for specific hour requirements for each health occupation. The modal number of hours required per year was 15 hours. The Minnesota State Licensing Boards which adopted the 15 hour requirement did so because it had become a national standard for relicensure (Boards, personal interview, April, 1991). No occupations utilized the Continuing Education Unit (CEU) as defined by the National Task Force on the Continuing Education Unit in 1970. If CEU's are reported, they are converted into contact hours.

Types of Continuing Education Accepted

Typically, the most common educational activities described are lectures or workshops which are designed to promote the continual development of professional knowledge, professional skills, and professional attitudes. Courses of greatest interest to practitioners reported research to improve skills or procedures. These courses are offered through colleges and universities, professional associations, and private educational corporations.

Several occupations will grant credit for self-directed learning and independent study educational activities such as home study, lecture presentation, and journal reading but usually there were limits on how many of these credits would be accepted each cycle for that activity. For example, the Board of Optometry would accept no more than 9 hours (20%) of continuing education through home study every three years whereas the Board of Medical Examiners would accept 20 hours for papers or published books and 20 hours of professional reading (40%) every three years. For specific details, refer to the occupational data sheets of optometry (see appendix G, page 106) and physician (see appendix G, page 113). See table 7 for a summary of the self-directed and independent study accepted for licensure/registration renewal.

Table 7.--Self-directed and Independent Study Activities Accepted by Licensing Boards

Education Activity	Occupations who accept	Hours Accepted per Year
Home study course- must include an examination	1*,2,3,4,6,7	9-20
Presentations/lectures at scientific meetings plus preparation (if first time presentation)	1*,3,5,7	2-20
Acceptance of articles in professional journals	3,4,5,7	3-10
Credit for published books	1*,3,4,5	9-10
Clinical rounds, one hour credit for every hour of clinical rounds.	3	9
Reading journal articles	3,5	9-20
Teaching of medical students	5,6	9-20
Peer patient review activities	5	20
Self assessment examinations	5	20
Hospital staff meetings	6	3

OCCUPATION CODE:
1. Dental Assistant, Dental Hygienist, and Dentist
2. Nursing
3. Optometry
4. Pharmacy
5. Physicians
6. Podiatry
7. Social Work

*The rules of the occupations of dental assistant, dental hygienist, and dentist do not limit the number of hours an individual may accrue in these areas. However, everything must be preapproved and no one has ever completed the requirement with only home study.

Content Requirements

Two State Boards—Optometry and Chiropractor Examiners—have the authority to mandate specific content or subject matter requirements of practitioners. The Board of Optometry has mandated specific content or subject matter as part of the continuing

education requirements. For example, in 1991, all licensed optometrists must take a course on professional ethics. Although the rules for Board of Optometry state that this is an option of the board, special topics have been required each year. For a list of topics required by the Board since 1988 see appendix G, page 106. These courses must be taken in the year in which they are required and are inclusive of the 45 hours required every three years. In 1992, the Board of Chiropractor Examiners will require eight hours training on sexual abuse recognition and professional boundaries (ethics).

Renewal Fees Required

The renewal fees are paid yearly for all 13 occupations even though the continuing education reporting cycle varied from one to 5 years. The renewal fees ranged from $17.00 for dental assistants to $225.00 for podiatrists. See table 6 for summary of renewal fees for regulated health care occupations in the state of Minnesota.

The fee is based on the number of licensees regulated by the board. The fees are used to finance the administrative costs of the licensing board which includes costs associated with enforcing the continuing education requirement. Therefore, the greater the number of licensees/registrants, the lower the fees. The licensing boards in the state of Minnesota are essentially self supporting. The State Legislature appropriates only a small amount of monies which includes funding for legal services from the Attorney General's Office. For a detailed summary of appropriations to licensing boards see appendix H, page 119.

Program Implementation Requirements

Program Approval

Nine of the thirteen health care occupations required preapproval for all of the courses being submitted for fulfilling continuing education requirements. The four occupations which do not require preapproval of continuing education were: nursing, physical therapy, physician assistant, and physician and surgeon.

Program approval requests were generated by both individual practitioners and sponsors. An individual practitioner could request credit for completing a correspondence course; a University professional school as a sponsor could request board approval for a one-day program. Once approved, the sponsors will then advertise such as "Board of Optometry has approved this course for six continuing education contact hours." In some cases certain courses (e.g. , workshops or National and Regional Conferences) did not require preapproval or were typically given automatic approval when submitted. See appendix I, page 121 for a sponsor application form and appendix J, page 124 for an example of an individual program approval form from the Board of Social Work.

Six of the nine occupations have continuing education committees which review programs for their Boards. For the other three occupations, it was the responsibility of the executive director and office staff of the supervisory Board to review programs. The committee or the executive director then makes recommendations to the State Board for approval or rejection of these programs for continuing education credit.

The number of programs approved from individuals and sponsors or providers ranged from 75 (optometry) to 8,900 (dentistry) courses. The Board of Marriage and Family Therapy has approved approximately 3,000 courses. The turn around time for courses ranged from 14 days to 45 days. See table 8 for the health occupations which required prior approval of continuing education programs and the approximate number of programs approved by each occupation during 1990.

An actual dollar cost estimate of this approval process was not available from the representatives who were interviewed. However, the impression of the investigator when exploring this area was that the process of program approval was time consuming and that using providers helped to reduce time spent reviewing courses for approval. One executive director referred to a stack of renewal applications which needed continuing education verification to indicate the amount of work involved.

Table 8.--Number of Approved Programs and Providers and Audits Performed

Occupation	Programs Approved & Number	Providers Approved & Number	Audits/Number
Chiropractor	yes / 250	In development	No
Dental Assistant	Yes / 8900	Yes / 212	No
Dental Hygienist	Yes / 8900	Yes / 212	No
Dentist	Yes / 8900	Yes / 212	No
Marriage and Family	Yes / 3,000	No	Yes*
Nurse -Registered	No	No	1%
Optometry	Yes / 75 to 100	No	No
Pharmacy	Yes / 15-20/month	Yes / 30 in Minnesota	No
Physical Therapy	No	No	2-3%
Physician Assistant	No	No	2-3%
Physician	No	No	2-3%
Podiatry	Yes / 80	No	No
Social Work	Yes / > 1,000	No	No

*The Board of Marriage and Family has just completed their first continuing education cycle and plans to audit the records of participation but the Board has not determined how many will be audited.

Program Providers

Program providers as defined here were organizations/institutions or groups of practitioners (e.g., dental study groups) or consultants/corporations which have completed an application process and have demonstrated their courses follow Board guidelines, and have been approved to offer courses. A sponsor is approved to offer a single course; a provider is approved to offer courses without submitting each course for Board approval. This approval is time limited.

There are four occupations which have mechanisms for granting approval of continuing education providers. Providers may offer courses for dental assistants, dental hygienists, and dentists once the provider is approved by the Board of Dentistry. The Board of Pharmacy also approves providers.

The standards for Board of Dentistry provider approval are as follows: the applicant is formally organized as a corporation, partnership, educational institution, or other formal association and has as one of its principal purposes the sponsoring of continuing dental education (CDE); the courses proposed by the provider must have significant intellectual or practical content which deals with the clinical and scientific aspect of dentistry and patient communication; and the applicant shall permit only those who are qualified by practical or academic experience to teach speak, lecture or make presentations at CDE courses. The Board of Dentistry has approved 212 providers who have been approved for four years.

Each provider of dental continuing education shall announce at least once during the course to all participants that they must submit to the provider their continuing education record within two weeks of completion of the course. The provider then must submit this documentation (cards) to the Board within three weeks after completion of the course.

The Board of Pharmacy approves providers based on the following criteria: the continuing education program must have an identifiable administrative authority who is responsible for meeting all quality criteria and for maintaining records of program content, planning, delivery, evaluation and attendance; records of participation in continuing education activities are maintained and are available; the provider provides evidence of completion for the participant; methods of delivery are consistent with the special needs of the program; competent teaching staff are used; and evaluation mechanisms must be provided to allow the participants to assess their achievement of program activities. Providers are approved for two years. The applicant must agree to maintain records for three years. The Board of Pharmacy has approved 30 providers in the state of Minnesota.

The Board of Chiropractor Examiners is developing a provider approval mechanism. The primary benefit to the use of providers is to reduce Board time in reviewing and approving courses. See table 8 for the occupations who approve providers and the number currently approved.

Audits

For those four occupations whose Boards do not require program approval, audits were utilized to verify MCE requirements. See table 8 for review of occupations that audit continuing education requirements. An audit is an individual review of the continuing education documentation for a randomly selected practitioner. For example, the Board of Nursing audits approximately 1% of the registered nurses each year and the Board of Medical Examiners audits approximately 2-3% of its practitioners. The audits by the Board of Medical Examiners and Board of Nursing are completed by Board staff. The Board of Marriage and Family Therapy plans to utilize both program approval and audits for monitoring continuing education requirements.

When a nurse is audited, he/she must provide the Board with a course outline, objectives, instructor qualifications, and the evaluation mechanism for each course attended during the reporting period. Each year practitioners sign a statement attesting to the fact that they have completed continuing education. These practitioners are on a honor system to complete their MCE.

Since these boards do not approve programs, the appropriateness of a course or activity is determined by the practitioner. The risk to the practitioner is that the board may deny the practitioner credit for a course when he or she is audited because it does not meet Board criteria for a continuing education activity.

In addition, any nurse who requested to defer his/her continuing education requirements (this can only be done once) was automatically audited. In 1988, the cycle period for nurses was changed from starting in January to coincide with their birth dates. This change has been phased in over the past three years making the current audits difficult

as some nurses had fewer than three years and some had more than three years at renewal time.

Documentation

The documentation of continuing education requested by the licensing boards from licensees consisted of three types: (1) documentation required to request program approval, (2) submitting documentation to report participation in a preapproved course, and (3) providing information required for an audit. Either of documentation types two or three may be utilized by a licensing board which audits practitioners.

The information required for preapproval requests includes: the date and time of the course, the sponsor, an outline of course, objectives, and the instructor qualifications. Some Boards required evidence of evaluation. It becomes more difficult if practitioners did not obtain prior approval for courses they attended. If the practitioner does not have satisfactory evidence, the Board may deny approval and thus credit. Overall, the Boards were generally forgiving when a practitioner requested approval after completion of a course.

Documentation to report participation of continuing education for preapproved courses could be a certificate of completion, a canceled check or a standard form (card). For example, dental assistants, dental hygienists, and dentists have cards provided by the Board of Dentistry and this card is signed by the program provider or sponsor sometime during the course. This card is then sent in to the Board of Dentistry. This process is computerized and the Board of Dentistry notifies licensees at the time of renewal if they are lacking hours. If they are lacking hours the renewal notice will not be sent out. In this situation, the licensee does not have to turn in any documentation since it is recorded by the Board of Dentistry as the card is completed and submitted to the Board. Pharmacists also keep a record of continuing education using a card system.

The documentation required by Boards which audited practitioners varied. The Board of Nursing required the following information from practitioners who were audited: objectives, verification received by the nurse of the number of contact hours (outline if more than four hours), documentation of each instructor's qualifications, evidence that the nurse used the mechanism which was provided to determine if learning occurred (e.g. checklist or test), and written verification of completion from the instructor. Nurses are required to keep records for two years. In contrast, the Board of Medical Examiners will accept certificates of attendance from physicians, physical therapists, and physician assistants or a canceled check as proof of attendance in their auditing process.

Evaluation

There were no occupations that required pre or post testing. The rules for pharmacy, nursing, marriage and family therapy, and social work did state that an evaluation mechanism had to be included but the exact mechanisms were not defined. These evaluation mechanisms often consisted of a satisfaction scale completed by the participant at the end of a course. Nursing was the only occupation to require a demonstration of skill. At least one of the acceptable continuing education activities required for registration renewal for nurses included evidence of having successfully demonstrated to an instructor a skill in performing one or a portion of a professional (RN level) nursing function.

Enforcement

Each state board is responsible for enforcing the continuing education requirement. The executive director investigates non-compliance and then makes recommendations to the board. The renewal approval is held or suspended until the licensee can provide proof of completion of continuing education requirements. The number of licensees who lost their licenses because of failure to obtain continuing education varied from two to 12 during 1990. See table 9 for specific numbers of licenses suspended in 1990.

Table 9.--Licenses Suspended or Revoked as a Result of Incomplete Continuing Education

Occupation	Number of Licenses Suspended/Revoked
Chiropractor	12
Dental Assistants	10
Dental Hygienist	8-9
Dentist	10-12
Marriage and Family Therapy	No history yet.
Nurse - Registered	Unsure due to recent cycle change.
Optometry	12
Pharmacy	1 out of 100
Physical Therapy	Rare
Physician Assistant	Rare
Physician	Rare
Podiatry	2-3
Social Work	No history yet.

In some cases, the Board will refer the licensee to a disciplinary committee because he/she falsified the renewal form. This occurred in those occupations which audit for the continuing education requirement; licensees had signed a form which attests that they completed the continuing education requirement. In addition, one board reported that licensees who have not completed the continuing education requirement are often times being disciplined by the State Board for other problems.

Once a license has been revoked for not fulfilling the continuing education requirement, the reinstatement usually required is completion of continuing education requirements or retaking part or all of the initial examinations for licensure/registration. If

the requirement is to complete unmet requirements for continuing education, this is in addition to the continuing education required for the next cycle. In general, the boards assisted practitioners in providing the right kind of documentation for the MCE requirement. However, in one case a licensee has paid up to $250 in fees and fines and has completed 140 hours of continuing education credit in order to be reinstated rather than retake the examination.

Benefits and Disadvantages

The outlook of six of the executive directors and the three staff members ranged from doubtful skepticism to staunch support in the belief that continuing education is beneficial. There was a feeling that the current MCE process was not perfect but that it was the best way to ensure practitioner competence until something better was developed. When asked about the advantages of MCE, some of the comments from interviewees were: "has helped to keep——up-to-date" and "Professionally we all get lazy; MCE forces professionals to comply". One executive director identified re-examination as an alternative to continuing education credits and felt that this was a possibility. This individual stated, "MCE is the only way to ensure continued protection of the public without relicensure" (i.e., retaking the examinations).

The advantages and disadvantages or problems of continuing education in the opinions of state board executive directors and staff are summarized in table 10. The advantage cited by four of the nine representatives was that MCE facilitates keeping up with new technology and three out of nine felt that MCE provides continued protection of the public. No one mentioned the same disadvantage more than once. The opinions were quite varied when asked about disadvantages and, in fact, two individuals deferred to comment on disadvantages.

Table 10.--Advantages and Disadvantages of Mandatory Continuing Education

ADVANTAGES	DISADVANTAGES
Facilitates keeping up with new technology.(4)	Individuals attend because they have to, not because they want to learn. (1)
Continued protection of the public.(3)	Decisions on what courses to attend may be based on location and areas of interest rather than on weaknesses. (1)
Benefits of informal learning through discussions with peers. (2)	Mandatory CE is generating a new industry. (1)
Prevents practitioners from becoming isolated. (2)	Legislature likes it as a means to ensure safety of the public although little research to support this concept.(1)
Keeps older practitioners up-to-date (1)	Bureaucracy of boards tends to lag behind the real world. Therefore requirements fall behind needs of the public. (1)
Belief that practitioners will learn. (1)	Monitoring completion or actual changes in behavior is really not done.(1)
	Special topic requirements difficult for the board to administer and practitioner to complete.(1)
	Costly. (1)
	Boards are determining what is acceptable and what is not acceptable course content and this may not meet the needs of the licensee.(1)

NOTE: Number in parentheses indicates how many individuals listed each advantage or disadvantage.

Discussion

The primary goal of licensure/registration is to protect the public through establishment of minimum levels of training. As reported in the findings, three of nine state board representative interviewed believed that the licensure/registration acts fulfill this goal for the health occupations in Minnesota. The modal level of preservice schooling for the health occupations reviewed was a baccalaureate degree; the range varied from nine

months (dental assistants) to professional doctorate degrees (physicians). All of the preservice programs for all 13 occupations are accredited by a national or state organization. Examinations developed by national testing organizations or professional associations are required for the initial license for all occupations. Mandatory continuing education is not now required for three health care occupations—licensed practical nurses, unlicensed mental health care workers, and psychologists.

Licensure acts were designed to prevent unqualified practitioners from performing duties performed by licensed professionals and registration acts are designed to protect a practitioner's title. However, there were inconsistencies in the use of these two forms of regulation. The findings illustrate how some professions may be only registered but in practice their regulation is as restrictive as a licensure act (i.e., physical therapy). In addition, some licensed occupations have difficulty restricting practice as in the case of social workers.

These inconsistencies may not be well understood by the public they are designed to protect. They are also confusing to the practitioners working in an occupation. The regulatory effectiveness of these regulations is weakened because of this variation. If the framing of regulations were uniform, then the public and practitioners alike would understand the implications and authority of the regulations.

Because of the changing technology, the legislature and the occupations are concerned with keeping practitioners current as changes occur. The modal number of hours required for MCE for these occupations was 15 hours per year. It was not clear how the 15 hour standard for continuing education was established. There was no correlation between the number of years of preservice schooling required or the job duties performed and the number of hours needed for continuing education. The average number of continuing education hours for dentists was 15 hours per year which is the same for professional nurses (RN) whose initial schooling was an associate degree. Also, the

number of hours required does not seem to be related to the extent of technological changes in the profession.

Most courses submitted for continuing education credit were lectures attended at programs or seminars. Although some occupations accept alternative educational activities, few practitioners participated in them.

The most striking element missing from the continuing education experience process was needs assessment. Practitioners are not asked to identify weaknesses in order to target continuing education activities that would address their individual needs.

All health occupations described the types of education activities that would be accepted for MCE but the monitoring of participant completion varied among the occupations. The occupations either required program approval of all courses or the occupation audited its licensees. The program approval process and the audits focused on content, method, and instructor qualifications rather than on evaluation. In fact, the rules of only four occupations required evaluation mechanisms.

The documentation of continuing education activities focused on participation or attendance rather than a demonstration of learning or a change in behavior. The occupations of dentistry and pharmacy had well developed methods for documenting attendance. But, in general, the documentation practices were cumbersome and difficult at times to verify. It was surprising that the Board of Medical Examiners would accept airplane ticket receipts as proof of attendance at an educational activity.

Several occupations are attempting to recognize the public need as well as the needs of the occupation. The Board of Optometry requires a specific subject each year that all licensees are required to complete. This subject is a critical topic as identified by the Board of Optometry. For the first time in 1989, the Board of Medical Examiners utilized patient complaints relating to prescriptions to identify a critical topic. A course was developed by the Board and was offered throughout the state of Minnesota. To date, the Board of

Medical Examiners has received fewer complaints related to prescriptions (Board, personal itnerview, April 1991).

The boards in general have identified professional ethics as a primary concern for the 1990s. Beginning in 1991, chiropractors will be required to complete eight hours on sexual abuse recognition and professional boundaries training.

Finally, the enforcement of the continuing education requirement varied among the occupations. Five boards of occupations have suspended practitioners for failure to complete continuing education requirements. But, overall, the boards were usually forgiving and provided plenty of opportunities for practitioners to provide proof of attendance.

CHAPTER 5

SUMMARY AND IMPLICATIONS

Background of the Study

This study reviewed and compared initial and renewal practices for licensure/registration of 13 health care occupations regulated in the state of Minnesota. With the rapid changes in health care technology and in reimbursement practices for health care, health occupations are seeking legal credentialing. Occupations are seeking legal credentialing for two reasons: first to protect the public from harm due to incompetent practitioners, and second to gain reimbursement from payors of health care services. Recently, payors of health care will pay only for services provided by a state credentialed practitioner. Currently, six health occupations are seeking registration or licensure.

The recredentialing process and mandatory continuing education are integral parts of the regulatory process. The amount of MCE required, the documentation procedures and the enforcement practices for licensing boards have not been carefully studied. In addition, the procedures and practices utilized by state licensing boards vary among occupations and from state to state.

The purposes of this study were to identify and compare components of MCE of health occupations currently regulated in the state of Minnesota. The investigator explored the initial requirements for licensure/registration and the practices of licensing boards in their enforcement of the MCE legislation.

Design of the Study

The Minnesota Statutes and Rules for 13 health care occupations were studied. These occupations were identified from a list of regulated health care occupations from the Minnesota State Department of Health. The criteria for inclusion of a health occupation in

the study were as follows: 1) the occupation is legally recognized in Minnesota either through licensure or registration, 2) practitioners have direct involvement with patient/client care (mental as well as physical), 3) continuing education is required for renewal of the license or registration, and 4) the occupation is regulated by a state licensing board.

A data summary sheet was developed for each occupation which included: initial requirements (schooling and examinations), and continuing education renewal requirements (hours/cycle required, program approval and audits, documentation of the education activities, and enforcement). Executive directors or their designee were then interviewed to clarify and expand on data compiled from the rules and statutes. Nine interviews were conducted as some licensing boards have authority over more than one occupation.

The State statutes and rules were reviewed for each of the 13 occupations and a data summary sheet was developed. The information compiled from the statutes and rules was verified by the interviewees during the interview. In addition, documents provided by licensing board staff were examined and reported on the data summary sheets.

Summary of Findings

Type of Regulations

Two types of legal regulation are used in Minnesota: licensure and registration. The purpose of licensure is to restrict title and duties performed by an occupation. Registration is defined as title protection which protects an occupational title but not the duties. Inconsistent use of these regulations by legislatures has occurred in Minnesota. There are occupations which are licensed but the scope of practice is so broad that the licensure act loses its impact to restrict other practitioners from performing duties of licensed practitioners (e.g., social workers). And, there are registration acts which become as restrictive as licensure (e.g. physical therapy).

The authority for the implementation of regulations for licensure usually led to the establishment of a licensing board, except for the three dental occupations which were

governed by one licensing board. Occupations which were registered were governed by a related health licensing board.

Initial Licensure/Registration Requirements

The initial licensure requirements included minimum levels of schooling and completion of specific examinations for all 13 occupations studied. The minimum level of schooling ranged from a nine-month technical program to a professional doctorate degree. The modal level of schooling was a baccalaureate degree. The preservice schooling for all of the occupations reviewed required accreditation from a state or national accrediting body. Practitioners were required to pass a written examination and—in some cases, a clinical examination as well—as part of their initial license requirement. Five occupations required an oral examination.

Renewal Requirements

Reporting Period and Number of Hours Required

The reporting cycle for the 13 health care occupations studied ranged from one year to five years, the modal cycle being a two-year cycle (n=7). The number of hours required during each cycle ranged from 15 to 75 hours. When the hours were averaged out per year, the hours ranged from five for dental assistants or 25 hours per year for physician assistants and physicians. The modal number of hours required was 15 hours.

The renewal fees are due each year except for nurses and social workers which have two-year fee schedules. The renewal fees ranged from $17 for dental assistants to $225 for podiatrists. These fees are based on the number of regulated practitioners. In the state of Minnesota, the licensing boards are appropriated minimal funds by the legislature for administrative costs.

Education Activities

Approved educational activities consisted of classroom/workshop, and self-directed learning and independent study educational activities such as home study, lecture presentations, journal reading, publications of books or articles, clinical rounds, and teaching of medical residents. Usually there were limits on how many hours of self-directed activities would be accepted each cycle. This limit ranged from nine to 20 hours. Most licensing boards awarded credit based on a 60 minute hour. There were three occupations which defined a contact hour as 50 minutes.

Program Approval

A program approval process was utilized by nine of the health care occupations. This process approved each individual course. A request for program approval may be generated by an individual practitioner or a sponsor. These requests are required prior to completion of the course to ensure board approval. This approval is granted by the licensing board. The number of courses approved by licensing boards ranged from 75 to 8900 courses (approximate total during 1990). Six occupations have continuing education committees which review courses submitted for approval; otherwise this review is performed by the executive director or other office staff. These committees or individuals then make recommendations to the licensing boards.

Two of the nine occupations which utilized a program approval process also have mechanisms to approve providers. A provider is approved after application to a licensing board. The provider demonstrates ability to follow board guidelines for course content, organization, and evaluation. The occupations of dentistry and pharmacy have provider approval mechanisms available and have approved 212 and 30 providers (Minnesota only) respectively. Providers approved by the Board of Dentistry are approved for four years. Providers approved by the Board of Pharmacy are approved for two years.

Audits

Audits were utilized by four occupations: nursing, physical therapy, physician assistants, and physicians and were planned to be utilized by marriage and family therapy. Therefore, the Board of Nursing and Board of Medical Examiners have been using audits to verify completion of continuing education requirements and the Board of Marriage and Family has planned to use audits but none has yet been completed (newly regulated). Except for the Board of Marriage and Family, boards who used audits did not approve programs.

Occupations which audit practitioners do not require any proof of attendance unless they are audited. Each year the practitioner signs a statement that he/she has completed the continuing education requirement. The licensing boards randomly select practitioners to be audited. The Board of Nursing audits approximately 1% of its nurses each year. The Board of Medical Examiners which governs physical therapy, physician assistants, and physicians audits approximately 2-3% of its practitioners in each occupation each year.

Documentation

There were three types of documentation required by licensing boards relating to MCE. Documentation may be required for program approval, proof of attendance, and documentation required if audited.

Documentation for programs requested by individual practitioners or sponsors usually included the following: program sponsor, date and time, outline of course, objectives, and qualifications of instructors. Four boards required an evaluation mechanism. Providers who are approved do not need to request approval for each program or course.

In 11 occupations, a certification of completion is submitted to the State Board. Two Boards stated that they would accept canceled checks as proof of participation. All sponsors and providers also submit names of participants or documentation records to the licensing boards. When the course is offered by an approved provider, a provider number

is given to the participants and reported on their continuing education report or card depending upon the occupation.

When a practitioner is audited, he/she must provide proof of completion and/or other course information. For some boards, a certificate of completion was adequate. The Board of Nursing required the most information: objectives, verification of the number of contact hours (outline if more than four hours), documentation of each instructor's qualifications, evidence that the nurse used the evaluation mechanism (e.g., checklist or test), and written verification of completion from the instructor.

Evaluation

There were no occupations that required pre or post testing. The rules for pharmacy, nursing, marriage and family therapy, and social work stated that an evaluation mechanism had to be included but the nature of the mechanism was not defined. These evaluation mechanisms most often consisted of a satisfaction scale completed by the participant at the end of a course. Nursing was the only occupation to require a demonstration of skill. At least one of the continuing education activities used for registration renewal required evidence of having successfully demonstrated skill in performing one or a portion of a professional nursing function to an instructor.

Enforcement

The primary goal of regulating an occupation is to protect the public from incompetent practitioners. It is not clear from the findings of this study if practitioners are maintaining their skills thus ensuring the public safety.

The number of licenses/registrations suspended or lost due to failure to complete the continuing education requirement ranged from two to 12 practitioners in 1990. Most boards were assisting practitioners in meeting this requirement. Practitioners were given ample opportunity to provide documentation for continuing education credits. Few

disciplinary actions were taken as a result of failure to comply with the continuing education requirement.

Benefits and Disadvantages

In the opinions of the licensing boards' staff, the most frequently reported advantages of MCE were continued protection of the public and facilitating keeping up with new technology. Other advantages included benefits of informal learning through discussions with peers, preventing practitioner isolation, and the belief that practitioners will learn.

The disadvantages, as identified by licensing board staff, included: individuals attend because they have to and not because they want to learn, decisions on what courses to attend may be based on location rather than on weaknesses, MCE is generating a new industry, legislators like it as a means to protect the public to relieve their consciences, the bureaucracy of boards tends to lag behind society (requirements fall behind needs of public), monitoring completion or changes of behavior is really not done, special topic requirements difficult for the board to administer and practitioners to complete, the process is expensive, and boards are determining what is acceptable and what is not and this may not meet the needs of the practitioner.

Implications of the Study

The results of this research project were intended to enlighten both theory and practice about the regulatory process and, specifically, mandatory continuing education for health care occupations in the state of Minnesota. Several implications have been drawn from the data and are presented here to guide future study and practice in this area.

Regulating Health Care Occupations

The findings regarding the inconsistency of the regulations and the overlap of functions between health care professionals has several implications. First, the public may

be confused about the purposes of these regulations and not know how to use them. If the regulations do not serve the members of the public, the cost of regulating health care professionals can outweigh the benefits of this process. If regulating individual practitioners is costly and confusing, perhaps regulating hospitals or institutions which are involved in health care should be regulated instead. Hospitals are already accredited by the Joint Commission of Accreditation on Hospital Organization (JCAHO). The JCAHO process already requires the use of credentialed professionals and evidence of continuing education for medical staff. Since this process is in place, it could be expanded to include health occupations of all kinds. The advantage of using a national organization is that practitioners who have had problems in one state could be tracked by this organization. Another argument is that JCAHO has implemented a Quality Improvement process for hospitals. All JCAHO hospitals are required to monitor activities and demonstrate continued improvements in the delivery of health care. Maintaining practitioner competence is central to this process. Therefore, continuing education activity could be monitored through the Quality Improvement plans hospitals already have in place.

Second, the overlap which commonly occurs between functions illustrates that licensure is not as restrictive as the state government would like to believe. With the rising costs of health care today, health care organizations need to use staff in as cost effective manner as possible. The licensure process tends to inhibit the cross training of practitioners or other innovative solutions to staffing problems. Since some duplication already exists, perhaps physicians—rather than licensing each group—should be licensed. The onus to provide safe care would be on the physician. The physician could delegate functions to meet the needs of the organization. Hospitals are now tracking practices such as patient's length of stay and complications characteristic for particular physicians. This could be a check on the system. If the physician delegates functions and the patients get better quicker and have fewer complications, then the goal of protecting the public is achieved.

Initial Requirements for Regulation

Five of the 13 occupations required work experience for licensure. If clinical skills as well as knowledge are important for protecting the public perhaps more work experience or internships should be required. This work experience should not limit entry into the occupation but instead provide qualified practitioners. Only four occupations required a clinical examination. Again, to assess performance more effectively, occupations should consider using more clinical simulation examinations in addition to the written examinations.

Recredentialing

The recredentialing data led to several implications for the required reporting period, the types of educational activities approved, the process of approving providers/sponsors, and enforcement procedures.

Reporting Period

The number of hours required typically was 15 hours. There were no data to support this number of hours. Perhaps it would be more appropriate to base the amount of education required on the changes that have taken place in the occupation. During some cycles, few changes may have taken place. In addition, the hour requirement does not take into consideration that some practitioners may need more or less time to learn a new skill. Should practitioners be required to learn skills or new technology they will not be using? Professional associations could identify major changes in their occupations and identify the appropriate practitioners for the new knowledge or skill. If continuing education were based on a thoughtful needs assessment, some practitioners would need more continuing education than the present required number of hours.

Education Activities

Most educational activities were lectures or seminars. Course designs which accommodate a variety of learning styles should be offered. Practitioners should also be encouraged to participate in experiences that would be most helpful to them. For example, a nurse should be able to arrange to spend a week or more working in an intensive care unit of a major trauma unit to improve critical care skills. If attendance at seminars is difficult, other methods of continuing education should be acceptable and the effectiveness of the activity should be based on learning outcomes rather than attendance. Needs assessment should be an integral part in selecting a continuing education activity. Practitioners should attend courses to improve skills and knowledge rather than to get their required number of hours.

Another function that licensing boards could fulfill is an advising or counseling role. Practitioners who need assistance finding the right course could contact their licensing board. Some boards do provide this type of information but the process is not formalized. Licensing boards could act as a clearinghouse for approved courses. Licensees should be able to call the licensing board for a listing of courses whether preapproval is required or not. Licensing boards need to take a more active role in directing practitioners to quality programs.

Evaluation

The rules of only four occupations required an evaluation mechanism as part of the continuing education activity. However, the nature of the mechanism was not defined. An effective evaluation mechanism is central to the whole process of assessing learning outcomes or changes in behavior. Since one of the goals of continuing education is the continued competence of the practitioner, evaluation mechanisms to assess competence need to be utilized. One method to accomplish this goal would be through employer performance evaluations. Not only could the performance evaluation identify the types of educational activities needed but it could be used to determine if the activity has been

effective. Another method would be for providers to require pre and post testing to monitor changes in knowledge and skill.

Providers/Sponsors of Continuing Education

The providers and sponsors of professional continuing education need to base the offering of courses on needs assessments. This could be accomplished through several mechanisms. First, the individual practitioners could complete self-examinations and a listing of continuing education activities could be generated after identifying areas for improvement from this examination. Second, employers could provide a list of problems areas or suggested topics after completion of yearly performance evaluations. The advantage here is that the continuing education would be geared toward pertinent skills practitioners need for their jobs. Finally , a third mechanism to identify needs of practitioners is through hospital incident reports, review of complications or law suits, or complaints to licensing boards. This would require investigation of situations which address problems.

Documentation

The entire system of documentation should be computerized. Practitioners should be able to know at any given moment to their status (e.g., "How many hours do I need for recredentialing?"). This would prevent individuals from finding out at the end of their cycle that they do not have enough hours or that their documentation was not acceptable and therefore they lack hours for recredentialing.

Enforcement

The findings reveal that few practitioners lose their license/registration due to failure to complete continuing education requirements. Even when this occurs, completion of the continuing education is usually all that is required to reinstate a license or registration. In fact, the attitude of one executive director was that failure to complete continuing education was not a valid cause for suspension of a license or registration. Because of these

practices, the enforcement of mandatory continuing education has lost credibility with the licensees/registrants. It becomes a mad rush to get the required number of hours just prior to the expiration of one's license regardless of the course value to the individual. Perhaps the enforcement should focus on learning outcomes rather than completion of continuing education hours. Rather than auditing the individual, licensing boards could audit the employers and patients served by licensees/registrants. Any weaknesses or complaints which arise would warrant further investigation. Complaints and/or complications could be reviewed by a committee of peers. This committee could recommend courses or experiences which would benefit the licensee/registrant and the protection of the public would be accomplished.

Implications for Adult Educators

The findings have several implications for adult educators. It is evident that the current continuing education practice has some weaknesses. One of the major weaknesses is the failure to identify the educational needs of the licensees/registrants. Needs assessment is an area where adult educators need to assist health professionals in identifying how to maintain competence. Adult educators could also assist health professionals in identifying their learning style and in seeking out the best education activities for their educational needs and learning style.

Another area in which adult educators could assist professionals and licensing boards is through program design. Adult educators traditionally have not been involved in the licensing board's administration of the rules. Adult educators could assist providers and sponsors to develop effective and perhaps innovative program designs which would be approved by the licensing boards. Assisting licensing boards in developing an outcome oriented process rather than a monitoring of participation would also be central to maintaining competence.

Implications for Research

There are several implications for future research. The current process and the costs of regulating health care professionals needs further study. Does the regulatory process protect the public? If so, how? Studies which investigate the direct and hidden costs need to be completed. Then the costs need to be compared to the benefits to the public. If the general public does not know how to recognize a licensed practitioner, are the costs of regulation justified? Studies which examine alternative methods of protecting the public need to be designed in terms of both effectiveness and efficiency.

The initial requirements for regulation need to be reviewed. What are reasonable initial requirements which would not limit the number of practitioners and increase costs? Is the examination process adequate? Are the nationally written examinations valid and sufficient as the only examination requirement? Research in alternative methods of assessing clinical skills and competency needs to be developed and evaluated.

In the area of recredentialing, research is needed to review the effectiveness of the current hour requirements. Can practitioner competence be assured through a pre-specified number of hours spent in educational activities? What are the most effective methods for maintaining competence?

Finally, further study is needed to learn how to evaluate the competency of practitioners. Whether an occupation is regulated or not this concept is critical toward providing safe and quality health care. Do different occupations require different methods of assessing competence?

Conclusion

The number of health care professionals seeking regulation is increasing at a time when the inflation of health care costs is in the double digits. In order to assure the goals that licensure was intended to meet, the legislature and the health care industry need to review the current regulatory process. In order for the regulatory process to be effective,

changes in the area of recredentialing are indicated. Licensing boards need to look for alternative program designs and evaluation mechanisms which focus on practitioner competence. Only when these are resolved can we hope to accomplish the original goal of protecting the public.

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INTERVIEWS: Personal interviews with executive directors or their designee were completed except for the Board of Podiatry which was a phone interview. All interviews are confidential and were completed the last part of April, 1991.

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Board of Dentistry
Board of Marriage and Family Therapy
Board of Medical Examiners
Board of Nursing
Board of Optometry
Board of Pharmacy
Board of Podiatry
Board of Social Work

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Board of Social Workers. 1990. Minnesota Statutes 148B.18: 4015-4021.

Optometrists. 1990. Minnesota Statutes 148.52 to 148.62:3990-3995.

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APPENDIX A.

HEALTH-RELATED OCCUPATIONS REGULATED BY THE STATE OF MINNESOTA

OCCUPATION	LICENSE	REGISTRATION	PERMIT	RENEWAL DATE
Audiologist		X		Annual
Chiropractor	X			Annual
Contact Lens Technician		X		to be determined*
Dentist	X			Annual
Dental Hygienist	X			Annual
Dental Assistant		X		Annual
Emergency Medical Technician		X		Biennial
Hearing Instrument Dispenser		X		Annual
Hearing Instrument Seller			X	Annual
Marriage & Family Therapist	X			Annual
Medical Doctor	X			Annual
Mortician	X			not available
Nurse, Registered	X			Biennial
Nurse, Practical	X			Biennial
Nursing Home Administrator	X			Annual
Occupational Therapist		X		to be determined*
Occupational Therapy Assistant		x		to be determined*
Optometrist	X			Annual
Osteopath	X			Annual
Pharmacist	X			Annual
Physical Therapist		X		Annual
Physician Assistant		X		Annual
Podiatrist	X			not available
Psychologist	X			Biennial
Respiratory Care Practitioner		X		Annual
Environmental Sanitarian		X		Biennial
Speech Language Pathologist		X		Annual
Social Worker	X			Biennial
Unlicensed Mental Health Service Provider			X	Annual
Veterinarian	X			Annual

Licensure is defined in Minn. Stat. 214.001 as "a system whereby a practitioner must receive recognition by the state that he has met predetermined qualifications, and persons not so licensed are prohibited from practicing." (Title and scope of practice protection.)

Registration is defined in Minn. Stat. 214.001 as "a system whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications." (Title Protection only.)

Permit requires all practitioners of an occupation to file practice information with the state and/or meet other requirements to protect public health.

* newly regulated

Revised: 5/91 k:hrominn.hop

APPENDIX B.

LICENSING BOARDS
Colonial Office Building
2700 University Ave W.
St. Paul, MN 55114

CHIROPRACTIC EXAMINERS		
Room #20	Exec. Director: Dr. Joel B. Wulff	642-0591
DENTISTRY		
Room #70	Exec. Director: Doug Sell	642-0579
HARMFUL SUBSTANCE COMPENSATION		
Room #115	Exec. Director: Jean Small-Johnson	642-0455
MARRIAGE AND FAMILY THERAPY		
Room #225	Exec. Director: Debbie Mancheski	643-2586
MEDICAL EXAMINERS		
Room #106	Exec. Director: H. Leonard Boche	642-0528
NURSING		
Room #108	Exec. Director: Joyce Schowalter	642-0567
NURSING HOME ADMINISTRATORS		
Room #104	Exec. Director: Phillip Newberg	642-0595
OPTOMETRY		
Room #103	Exec. Director: Dr. Burton Skuza	642-0594
PHARMACY		
Room #101	Exec. Director: David Holmstrom	642-0541
PODIATRIC MEDICINE		
Room #101	Exec. Director: Lois Mizuno	642-0588
PSYCHOLOGY		
Room #101	Exec. Director: Lois Mizuno	642-0587
SOCIAL WORK		
Room #225	Exec. Director: Michael Dean	643-2587
OFFICE of SOCIAL WORK & MENTAL HEALTH BOARDS		
Room #225	Business Manager:	643-2585
UNLICENSED MENTAL HEALTH PRACTITIONERS		
Room #225	Exec. Director: Robert A. Sullivan	649-5490
VETERINARY MEDICINE		
Room #102	Exec. Director: Roland C. Olson, DVM	642-0597

APPENDIX C.

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION:

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	
INITIAL LICENSURE/REGIST: Education:	
Experience:	
Testing: National or state exam? Exemptions?	
Other:	
RENEWAL REQUIREMENTS: CE: Hours/ year/s	
Yearly fee:	
CEU or contact hours or both or either or self planned.	
Subjects or content:	
Proof of attendance. Documentation.	
Program provider requirements:	
Criteria for program approval.	
Exceptions to approved programs.	
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	
ROLE OF CE IN reinstatement.	

APPENDIX D.

Interview for Executive Directors of licensing boards of health occupations in Minnesota.

EXECUTIVE DIRECTOR_____DATE_____

I. We would like to find out more about the form of regulation for your occupation.

If registration is the form of regulation, does it restrict the practice to those who are registered?

Probe:

How defined in field?
Required?
Voluntary? If voluntary, how many practitioners are registered? Do you know what is the total number of practitioners in the state of MN?
If licensure, is the practice truly restricted to those who are licensed, for example a doctor can practice nursing? How many practitioners are licensed in MN?

II. History of your act.

In what year was it passed (first legislation)?
Was CE a part of the original act? If not when was it included?

What has been the rationale for these including CE as part of the regulations?

III. In the outline I sent you, are the requirements for initial license accurate?

Testing by national or state exam?

QUESTIONS RELATING TO RENEWAL (See outline).

IV. Now, I would like to ask some questions about the mandatory continuing education requirements.

Is continuing education based on CEU's, contact hours, or other?

Have the boards ever accepted experience other than CEU's or contact hours?

If so how often? Describe the experience.
Subjects/content most often attended?

What documentation is needed for proof of attendance? What do practitioners need to submit for renewal?

V. The mandatory continuing education activity.
Are objectives required for CE courses?

Is a pre test required?
Is a post test required?

Is evaluation a required component, if so what kind?

How many providers are approved (if applicable)?

Who or what type of organization is the typical provider/sponsor for your profession?

Once a provider has been approved are all of their courses automatically approved?

Program approval: How many programs are approved per year?
Not approved?

Who reviews the programs for approval?

VI. We would like to ask some questions about the enforcement of the mandatory continuing education requirement.

Who is involved in enforcement of the CE for registration/licensure renewal?

What is their role?

What forms does enforcement take?

Probe: Audits?
How many?
How often?

What happens when educational requirements are not met?

How many practitioners per year do not meet this requirement?

In 1990, how many disciplinary actions/suspensions of license have been occurred related to not meeting the CE requirement?

VII. Are you aware of any situations where the CE process has been abused?

Examples of how abused?

How many were reported in 1990?

What formal action has been taken if abuses have been documented?

Probe: If none, rationale?
Who determines?
What are minimum/maximum penalties?

VIII. I would like to ask some questions about continuing education requirements in other states.

Do you know how many other states require continuing education in your profession?

How do MN requirements compare with those in other states?

What is the role of the national professional organization in the process? Are programs sponsored by the national organization automatically approved?

IX. In your opinion,

What have been the advantages of mandating continuing education for your profession in Minnesota?

Are practitioners more competent to perform their jobs as a result of CE?

(Evidence of improved competency, i.e. fewer complaints from the public?)

Are there any disadvantages in mandating continuing education?

X. What changes would need to be made from the present practice to improve the current CE process?

Are there any changes in the CE requirement planned for the near future? If so please describe.

XI. Do you have information on the average cost/year/practitioner Do you know the salary range of the profession/s?

APPENDIX E.

UNIVERSITY OF MINNESOTA

Committee on the Use of Human Subjects in Research
Office of Research and Technology Transfer

Suite 201
1100 Washington Avenue South
Minneapolis, MN 55415-1226
612-624-9829
Fax: 612-624-4843

April 17, 1991

Beth A. Green-Eide
4420 Brockton Lane

Minneapolis MN 55455

RE: "Review of Mandatory Continuing Education of Regulated Health Professions in Minnesota"

HUMAN SUBJECT CODE NUMBER: 9104E3697

Dear Beth A. Green-Eide:

The University of Minnesota Committee on the Use of Human Subjects in Research has determined that the referenced study is exempt from review under federal guidelines 45 CFR Part 46.101(b) category #3 SURVEY/INTERVIEW PROCEDURE.

The above code number is assigned to your research. That number, along with the title of your study, must be used in all communication with the Committee office.

Upon receipt of this letter, you may begin your research. If you have questions, please call me at (612)624-9829.

The Committee wishes you every success with this research.

Sincerely,

Ellen Stewart

Ellen Stewart
Executive Assistant

EHS/cdl

ADVISOR CC: Harlan Copeland

APPENDIX F.

CONSENT FORM

You are invited to participate in a study of health care professions in Minnesota. This study is being conducted by Beth Green-Eide to fulfill my requirement for a Masters degree. Currently I am Director of Respiratory Care Services at St. Paul Ramsey Medical Center.

I hope to compile information which reviews the mandatory continuing education requirements for health professions in Minnesota. You were selected because you are an executive director of a licensing board.

If you decide to participate I will interview you regarding your regulatory act and components of the mandatory continuing education requirements. The interview will take approximately 45 minutes.

Any information obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

If you have any questions about the research and/or research subjects/rights, please call Beth Green-Eide, 221-2723 or Dr. Harlan Copeland, 625-0882.

You will be offered a copy of this form to keep.

Your decision whether or not to participate will not affect you future relations with the University of Minnesota in any way. If you decide to participate, you are free to withdraw at any time without affecting such relationships.

_____ _____

Signature of subject Date

_____ _____

Signature of Investigator Date

APPENDIX G.

OCCUPATION: Chiropractor

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Chiropractor - Board of Chiropractor Examiner's: MN Rules Chapter 2500
MN Statutes 148.01-148.106

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	License Total 1500, active 1300. Initial regulation 1919.
INITIAL LICENSURE/REGIST: Education	One half of baccalaureate degree in subject matter determined by board (same as in a college of good standing (i.e. U of M or community college) or college of chiropractic that is accredited by Council on Chiropractic Education.
Experience:	
Testing: National or state exam? Exemptions?	Two part state exam. First part covers nutrition, jurisprudence and historical perspectives. Second part is a practical clinical examination (licensed chiropractors act as patients and examiners). The national examination is also required and is usually completed sometime before graduation from their program.
Other:	NONE
RENEWAL REQUIREMENTS: CE: Hours/ year/s	40 hours every two years with 6 hours of radiologic study. CE required approximately since 1975.
Yearly fee:	$100.00
CEU or contact hours or both or either or self planned.	One continuing education hour is defined as 60 minutes. Board must approve courses. The executive director reviews all courses and makes recommendations to the Board. Goals or objectives required. No tests. No self study or home study approved.
Subjects or content:	Most often course deal with disseminating new research i.e. studies which question old techniques. In 1992-1996 , 8 hours on sexual abuse recognition and professional boundaries training will be required.
Proof of attendance. Documentation.	CE card is checked against approved course list. Sponsor of program must send verification quarterly. If not initially licensed in this state during the preceding calendar year shall: submit a written statement containing name, date, and subject or each educational program, names of the sponsoring organizations, number of 60 minute class hours of instruction offered at each program and # or hours actually attended.
Program provider/sponsor requirements:	Approval for providers is in development.

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OCCUPATION: Chiropractor

Criteria for program approval.	Written request to board 45 days prior to program which includes sponsoring organization, outline, instructor name and credential, # of 60 minute hours of actual instruction, mechanism of monitoring and certifying attendance, dates of course, tuition fee. Courses/programs meet the following criteria; a. material will enhance practitioners knowledge, b. instructor is qualified, c. setting is conducive to learning. Typically meetings of the American Chiropractic Association, International Chiropractic Association, California Chiropractic Association, and chiropractic college sponsored courses will be approved by the board. Courses dealing with administrative and economic aspects of practice shall not be approved for CE credit by the board. About 250 programs approved each year.
Exceptions to approved programs.	None
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	If CE not met, renewal is refused (license limbo, hearing is required unless hours are made up before hearing). During 1990, 40 practitioners were refused renewal and 12 will probably be revoked.
ROLE OF CE IN reinstatement.	Once revoked a. Must make up CE course hours and subject matter requirements which would have been required and proof of attendance at 10 hours of board recognized CE for each intervening renewal year. Individuals have paid as much as $2500 and taken 140 hours of CE instead of retaking exam. b. Reexamination by the board.

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OCCUPATION: Dental Assistant

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Dental Assistant - Board of Dentistry Chapter 3100

DATA	INFORMATION FROM THE REGULATION and INTERVIEW
REGULATION/ACT:	Registration: Total 4082, active = 3351
INITIAL LICENSURE/REGIST: Education:	Certified copy of diploma or certificate of completion of program approved ADA Commission. Training needs to include specific duties i.e. radiologic skills. (See 3100.8500). 9-12 months in length.
Experience:	NONE
Testing: National or state exam? Exemptions?	Passing score on a board approved registration examination. The board provides a pool of questions for a testing agency which then constructs the test.
Other:	Photograph and evidence of good moral character.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	25 hours every 5 years of approved continuing dental education (CDE) by board.
Yearly fee:	$17.00
CEU or contact hours or both or either or self planned.	One continuing education hour is 60 minutes. Courses presented by sponsors shall fix the CDE credit based on the following: a. multi-day convention-type meetings such as state or national dental conventions or their equivalent will be given 3 clock hours credit. b. scientific or educational meetings or courses or similar offerings will be credited on an hour-for-hour basis. c. Home study with an accompanying examination will be awarded hourly credit if the examination is successfully completed based upon a determination by the board or sponsor of the reasonable amount of time to complete material and take the exam. d. presentation of course made on behalf of an approved sponsor will be credited on an hour-for-hour basis.
Subjects or content:	Registrants may earn no more than 5 hours on nonclinical subjects. Nonclinical subjects relating to the dental profession are: skills related to dental services in general not directly related to but supportive of clinical services i.e., patient management, legal and ethical responsibilities of the dental profession and stress management. Subjects not considered are estate planning, financial planning, marketing, investments, and personal health.

OCCUPATION: Dental Assistant

Proof of attendance. Documentation.	Within two weeks after completing a course given by a sponsor, the registrant shall fill out the form supplied by the board for reporting participation in CDE courses and submit it to the board (this have sponsor number on it. If not sponsor approved course, licensee reports course within two weeks after completion of the course or board may refuse credit. Cards are completed.
Provider/sponsor requirements: (Sponsor is the term used by the Board of Dentistry and means the same as provider.)	Sponsor may apply to the board and every 4 years. 212 sponsors have been approved, about 10 requests per year. Standards for sponsor approval are: organized as a corporation , partnership, accredited education institution, or other formal association and has as one of its principle purposes the sponsoring of CDE courses. Courses proposed by a sponsor must have significant intellectual or practical content which deal in the clinical and scientific aspect of dentistry and patient communication or in nonclinical subjects relating to the dental occupation. Shall permit only whose who are qualified by practical or academic experience to teach, speak, lecture or make presentations at CDE. Typical sponsors are professional associations or study clubs which are composed of a group of dentists.
Criteria for program approval.	Registrants may apply individually for approval of CDE courses by providing the following information. a. Name and address of the organization sponsoring the course for which credit is requested. b. Name and address of the person for correspondence. c. Detailed description of the content of the course. d. Name of each instructor and credentials. e. Location of course. No courses will be approved which involves TV viewing in the home, correspondence work, or self study only. 8900 course numbers were issued in 1990, 6500 were not from sponsors (approximate numbers). Office personnel review programs and make recommendations.
Typical sources of CDE.	Lectures, study clubs, college postgraduate course, scientific sessions of conventions, research, graduate study, course presentation made on behalf of an approved sponsor, and home study with a testing mechanism supplied by the sponsor (must complete and pass test). Subjects most often attended are clinical in nature.
Exceptions to approved programs.	No CDE required if licensee/registrant resides outside state and does not practice in state, or retired from practice, or permanently disabled.
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	Board sends out notice, when registration expires, terminating right to practice. Not considered discipline. May request to extend expiration by six months. Approximately 10 dental assistants lost a registration due to not meeting the CE requirement.
ROLE OF CE IN reinstatement.	Submit completed CDE requirements and must retake exam. If lapsed more than five years, must take the exam.

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OCCUPATION: Dental Hygiene

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Dental Hygiene - Board of Dentistry Chapter 3100

DATA	INFORMATION FROM THE REGULATION and INTERVIEW
REGULATION/ACT:	Licensure: Total 2785, active =1985
INITIAL LICENSURE/REGIST: Education:	Diploma from American Dental Association (ADA) accredited school. Can be 2 or 4 years in length.
Experience:	NONE
Testing: National or state exam? Exemptions?	Pass ADA examination and Central Regional examination (clinical part).
Other:	Photograph and evidence of good professional character.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	40 hours every 5 years of approved continuing dental education (CDE) by board.
Yearly fee:	$ 25.00
CEU or contact hours or both or either or self planned.	One continuing education hour is 60 minutes. Courses presented by sponsors shall fix the CDE credit based on the following: a. multi-day convention-type meetings such as state or national dental conventions or their equivalent will be given 3 clock hours credit. b. scientific or educational meetings or courses or similar offerings will be credited on an hour-for-hour basis. c. Home study with an accompanying examination will be awarded hourly credit if the examination is successfully completed based upon a determination by the board or sponsor of the reasonable amount of time to complete material and take the exam. d. presentation of course made on behalf of an approved sponsor will be credited on an hour-for-hour basis.
Subjects or content:	Licensee may earn no more than 8 hours on nonclinical subjects. Nonclinical subjects relating to the dental profession are: skills related to dental services in general not directly related to but supportive of clinical services i.e. patient management, legal and ethical responsibilities of the dental profession and stress management. Subjects not considered are estate planning, financial planning, marketing, investments, and personal health.

OCCUPATION: Dental Hygiene

Proof of attendance. Documentation.	Within two weeks after completing a course given by a sponsor, the licensee shall fill out the form supplied by the board for reporting participation in CDE courses and submit it to the board (this must have sponsor number on it. If course is not a sponsor approved course, licensee reports course within two weeks after completion of the course or board may refuse credit. Cards are completed.
Provider/sponsor requirements: (Sponsor is the term used by the Board of Dentistry and means the same as provider.)	Sponsor may apply to the board and every 4 years. 212 sponsors have been approved, about 10 requests per year. Standards for sponsor approval are: organized as a corporation , partnership, accredited education institution, or other formal association and has as one of its principle purposes the sponsoring of CDE courses. Courses proposed by a sponsor must have significant intellectual or practical content which deal in the clinical and scientific aspect of dentistry and patient communication or in nonclinical subjects relating to the dental occupation. Shall permit only whose who are qualified by practical or academic experience to teach, speak, lecture or make presentations at CDE. Typical sponsors are professional associations or study clubs which are composed of a group of dentists.
Criteria for program approval.	Licensees may apply individually for approval of CDE courses by providing the following information. a. Name and address of the organization sponsoring the course for which credit is requested. b. Name and address of the person for correspondence. c. Detailed description of the content of the course. d. Name of each instructor and credentials. e. Location of course. No courses will be approved which involves TV viewing in the home, correspondence work, or self study only. 8900 course numbers were issued in 1990, 6500 were not from sponsors (approximate numbers). Office personnel review programs and make recommendations.
Typical sources of CDE.	Lectures, study clubs, college postgraduate course, scientific sessions of conventions, research, graduate study, course presentation made on behalf of an approved sponsor, and home study with a testing mechanism supplied by the sponsor (must complete and pass test). Subjects most often attended are clinical in nature.
Exceptions to approved programs.	Other forms of CDE: Publication of articles or books will granted on an individual basis. No CDE required if licensee resides outside state and does not practice in state, or retired from practice, or permanently disabled.
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	Board sends out notice, then license/registration expires, terminating right to practice. Not considered discipline. May request to extend expiration by six months. Approximately 8 or 9 dental hygienists lost their license due to not meeting the CE requirement last year.
ROLE OF CE IN reinstatement.	Submit completed CDE requirements. Must retake one or other of the exams. If lapsed more than five years, must take the exam.

OCCUPATION: Pharmacy

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Pharmacy - Board of Pharmacy MN Rules Chapter 6800

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	Licensure Total: 4600 (3400 with MN addresses)
INITIAL LICENSURE/REGIST: Education:	Copy of birth certificate Graduation with BS or doctor of pharmacy from institution meeting minimum standards of Council on Pharmacy Education.
Experience:	Affidavits of internships. 1500 hours of practical experience some of which is completed through course work.
Testing: National or state exam? Exemptions?	Pass the National Association for Board of Pharmacy Licensing Examinations (NABPLEX), MN lab practical and Federal Drug Law Review and the MN Drug law examinations. The lab practical is given at the school of pharmacy and licensees fill prescriptions. The state law examination and the lab practical are both written by the state board. May take only three times. Retakes must be within 14 months.
Other:	A recent photograph.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	30 hours every 2 years.
Yearly fee:	$65.00
CEU or contact hours or both or either or self planned.	One continuing education hour is 60 minutes. Board must approve CE. The Continuing Educati[illegible] Advisory Task Force reviews all courses and requests for sponsors. Self study and home stu[illegible] approved if provided by an approved sponsor.
Subjects or content:	CE is defined as a planned learning experience beyond a formal undergraduate degree program designed to promote the continual development of professional knowledge, skill, and attitudes and shall include but is not limited to professional postgraduate education in any of the following subjects: 1. properties and actions of drugs and drug dosage forms. 2. etiology, characteristics and therapeutics of the disease state, 3. pharmacy practice. 4. legal, psychological, and socioeconomic aspects of health care.
Proof of attendance. Documentation.	Completion of Biennial Pharmacy Continuing Education Record card. See sample.

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OCCUPATION: Pharmacy

Program provider/sponsor requirements:	Complete MN provider application form and meet such requirements as clear advertising, maintenance and availability of records of participation, evidence of educational content development, evaluation mechanisms to allow the participants to assess their achievement of program objectives, techniques to assess the effectiveness of the CE activities. Providers approved by the American Council on Pharmaceutical Education (ACPE) are automatically approved. MN has approved about 30 providers and there are currently over 300 nationally approved sponsors by the ACPE.
Criteria for program approval.	Must fulfill requirements such as responsible advertising, provider agrees to maintain records of participation for not less than three years, designed to satisfy needs, includes educational goals, behavioral objectives, or both, that are measurable, and evaluation mechanism is provided, teaching staff appears to be competent in the subject matter and qualified by experience. Home study is approved if approved by the ACPE.
Exceptions to approved programs.	The individual must submit application for credit 45 days after completing the program. Shall provide title, site, date, type, and length of the program being proposed, outline, and description of evaluation mechanism. May apply for credit for presentation of in-service training program or lectures. Credit for presentation will be granted only once to any individual during any reporting period. The CE Advisory Task Force reviews about 15-20 requests per month.
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	If the CE has not been completed a renewal notice is NOT sent out. One out of 100 pharmacists do not meet CE. Usually they will provide some proof of completion i.e., canceled check or certificate of attendance. May request an extension but must still complete 30 hours every 2 years.
ROLE OF CE IN reinstatement.	Can reinstate within two years if CE completed or must retake exams.

OCCUPATION: Physical Therapy

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Physical Therapy - Board of Medical Examiners MN Rules Chapter 5601
MN Statutes 148.64 to 148.78

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	Registration - mechanism is similar to licensure. Total: 2800
INITIAL LICENSURE/REGIST: Education:	60 academic credits or its equivalents in biology and physical sciences. An accrediting course in Physical Therapy education - Board may use accreditation of American Medical Association (AMA), American Physical Therapy Association.
Experience:	None
Testing: National or state exam? Exemptions?	Examination is a national physical therapy examination developed by the National Board of Physical Therapy. Given by a testing agency.
Other:	Recommendation by one physician duly licensed to practice medicine in the United States or Canada and one physical therapist duly registered to practice physical therapy in the US or Canada.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	20 hours every 2 years.
Yearly fee:	$20.00
CEU or contact hours or both or either or self planned.	One continuing education hour is 60 minutes.
Subjects or content:	
Proof of attendance. Documentation.	2-3 % of registrants are audited each year.
Program provider requirements:	The Board of Medical Examiners (BME) does not approve any sponsors.
Criteria for program approval.	The BME does not approve individual programs.
Exceptions to approved programs.	
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	Rare
ROLE OF CE IN reinstatement.	

OCCUPATION: Physician Assistant

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Physician Assistant - Board of Medical Examiners MN Rules 5600.2600

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	Registration
INITIAL LICENSURE/REGIST: Education:	Successfully complete a physician assistant training program recognized by the board as approved by a national accrediting body for physician assistant training.
Experience:	
Testing: National or state exam? Exemptions?	Complete national exam approved by board.
Other:	An agreement with a physician which provides for plans for supervision, restriction and instruction, etc., approved by the board.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	50 contact hours every 2 years.
Yearly fee:	$40.00 plus surcharge for first five years
CEU or contact hours or both or either or self planned.	One continuing education hour is 60 minutes. Only formal education course similar to Category 1 for physicians are approved.
Subjects or content:	Contents related to scope of practice, i.e. taking complete histories, performing physical exams, interpreting and evaluating patients data as authorized by physician, initiating requests for diagnostic tests, performing therapeutic procedures, providing instruction and guidance regarding medical care matters to patients, and assisting the supervising physician in delivery of services to patients.
Proof of attendance. Documentation.	2-3% of licensees are audited each year. A log is submitted when audited. Documentation may come directly from the registrant or from a national accrediting or certifying organization which maintains those types of records.
Program provider requirements:	Program sponsors shall maintain attendance for 3 years. In practice the BME does not approve sponsors.
Criteria for program approval.	Education activity must have specific with written objectives which describe expected outcomes . Presented by knowledgeable persons who have reviewed the development in the subject being covered within the last two years. Must utilize a mechanism to validate participation. In practice the BME does not pre-approve any programs or courses.

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OCCUPATION: Physician Assistant

Exceptions to approved programs.	
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	a. Refuse to grant or renew a registration. b. Revoke a license. c. Suspend any registration for a definite period. d. Administer a reprimand. e. Condition or limit or restrict a registration. f. Place the physician assistant on probation.
ROLE OF CE IN reinstatement.	Fulfill terms of suspension.

OCCUPATION: Physician and Surgeon

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Medicine and Surgery - Board of Medical Examiners MN Rules Chapter 5600 and Chapter 5605

DATA	INFORMATION FROM THE REGULATION and INTERVIEW
REGULATION/ACT:	Licensure 13,000 physicians
INITIAL LICENSURE/REGIST: Education:	Graduate of a medical school or osteopathic college. Submit original or certified copy of the diploma from medical college degree or Doctor of Medicine. Include transcript if in the final year of training, then provide diploma.
Experience:	Completion of one year of graduate, clinical medical training in accredited program.
Testing: National or state exam? Exemptions?	Within 3 years before or 5 years after granted degree of Doctor of Medicine or Doctor of Osteopathy the applicant passes an examination prepared by National Board of Medical Examiners given by the medical schools and the Federation of Licensing Examinations, a cooperative state exam administered by the state.
Other:	Certificate of good moral character signed by two licensed physicians in medicine or surgery. A recent photograph.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	75 hours every 3 years.
Yearly fee:	$115.00 Total: 13,900 (9500 with MN address)
CEU or contact hours or both or either or self planned.	Credit obtained in the following activities: One hour of credit = 60 minutes. a. Category 1 - no less than 45 credits must be obtained in any cycle by attendance at education activities approved by the board. b. Category 2 - No more than 20 hours of credit may be obtained through educational activities sponsored by a hospital, clinic, or medical or osteopathic society and not meeting the standards in category 1. c. Category 3 - No more than 20 hours credit may be obtained through medical teaching of medical students, residents, practicing physicians, and allied health professionals. d. Category 4 - No more than 20 hours of credit may be obtained for papers, publication, books, lectures, and exhibits. Papers , publications, and books = 10 hours. Lectures - an hour of credit for each hour spent lecturing at a course which qualifies for approval. Exhibits and nonpublished papers = 10 hours of credit for a paper presented before a professional medical or allied health audience. e. Category 5 - No more than 20 hours of credit may be obtained by engaging in professional reading, peer patient care review activities, self-assessment examinations sponsored by a professional organization recognized by the board.
Subjects or content:	See criteria for program approval.

OCCUPATION: Physician and Surgeon

Proof of attendance. Documentation.	2-3% of the licensees are audited each year. When audited the licensee submits a log of courses completed. Rare for licensees to not meet the CE requirements.
Program provider/sponsor requirements:	Board does not approve any sponsors. All courses sponsored by medical schools or professional associations are automatically approved. However, in 1989 the Board sponsored and conducted a course as a result of increased disciplinary actions relating to prescribing of medications. It was provided throughout the state and 110-1200 physicians attended. In 1990 there were fewer disciplinary cases relating to prescribing.
Criteria for program approval.	According to the MN Rules, any person or organization may submit a course for approval by the board. Submit: Name and address of the organization sponsoring the course, a detailed description of the course content including time schedule for the course, name of each instructor or person making a presentation and credentials, location including name and address of the facility. For category 1: The educational activities shall have significant intellectual or practical content dealing primarily with matter directly related to the practice or professional responsibility or ethical obligations. Each person making a presentation shall be qualified by practical or academic experience to teach the subject. Attend educational activities in classroom, laboratory or setting suitable for the activity. Ordinarily, credit will not be given for speeches given at lunches or banquets. Any course planned, sponsored, or co-sponsored by a medical or osteopathic medical school, state or national medical or osteopathic association or a national medical specialty society shall be presumed to meet the above standards (board may withdraw this). **The board does not pre-approve any programs, they only audit licensees.**
Exceptions to approved programs.	The board may accept certification or recertification by an American specialty board in lieu of compliance with the CE requirements during a cycle.
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	The board may refuse to renew, suspend, condition, limit, or qualify the license of any person whom the board determines has failed to comply with the requirements. It becomes a matter of falsification of records.
ROLE OF CE IN reinstatement.	

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OCCUPATION: PODIATRY

DATA SUMMARY SHEET FOR REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Podiatry MN Rules Chapter 6900:0010

DATA	INFORMATION FROM THE REGULATION AND INTERVIEW
REGULATION/ACT:	License. Total: 120
INITIAL LICENSURE/REGIST: Education:	Transcript from accredited college (CA, NY, OH, PA, Scholl College(IL), IA). Accredited by the Council on Podiatry Medical Education. Date of graduation, degree granted, and official seal.
Experience:	Since 1987, clinical residency or other graduate training-12 months in length and approved by American Podiatry Medical Association.
Testing: National or state exam? Exemptions?	Passing score on National Board of Podiatric Medical Licensing Examination. Submit copy of score with seal. Three part examination: theory, photo identification, and patient problem/simulation part.
Other:	Good moral character. Interview with the executive director. Waived if board knows you.
RENEWAL REQUIREMENTS: CE: Hours/ year/s	15 clock hours per year. To be changed to every 2 years. CE first required in 1987.
Yearly fee:	$225.00
CEU or contact hours or both or either or self planned.	One continuing education hour is defined as 60 minutes.
Subjects or content:	Related to practice of podiatry. Subjects such as practice management, risk management or those not of a scientific nature are not acceptable. Objectives and tests not required for programs unless they are video, mail or home courses. Future change: risk management as it relates to invasive procedures will be included.
Proof of attendance. Documentation.	Evidence of participation in the form of a certificate, descriptive receipt, or affidavit. Board has approved programs.
Program provider/sponsor requirements:	Board does not approve sponsors just programs. Typical providers are podiatric schools or medical schools. The Council on Podiatric Medical Education does approve programs but these may not be approved on the local level. Sponsor must provide the attendee a written statement of attendance that includes the name and dates of the program, mane and address of the sponsor, the number of CE clock hours granted by the sponsor, the name of the attendee and a signature of the sponsor or designee, or upon completion of the program, the sponsor must send the board a list of attendees.

OCCUPATION: PODIATRY

Criteria for program approval.	Requirements: Content must be directly related to the practice of podiatric medicine as defined in MN Statutes, speaker must be a licensed podiatrist, other credentialed health care professional, or person especially qualified to address the subject. Podiatrist may submit program for approval. Board approves each program. Programs are previewed by the executive director and a staff member, they make recommendations to the board. Eighty courses approved last year and 3 denied. Only one home course approved so far.
Exceptions to approved programs.	Attendance at hospital staff meeting (no more than three hours). Participation in a clinical residency or preceptorship or graduate training.
ENFORCEMENT: Disciplinary actions if CE not completed? BY WHOM?	Board may take disciplinary action to suspend, revoke, limit, or refuse to renew the license of any podiatrist failing to comply with CE requirement. If CE requirements not met renewal is denied. There are 2 or 3 denied each year. They lose their license to practice.
ROLE OF CE IN reinstatement.	

OCCUPATION: SOCIAL WORK

DATA SUMMARY SHEET REGULATED HEALTH OCCUPATIONS IN MN.

OCCUPATION: Social Work - Board of Social Work MN Statues 148B.18 MN Rules Chapter 8740

DATA	INFORMATION FROM THE STATUTES			
Social work area: Total: 9300	Social workers LSW	Graduate social workers LGSW	Independent social workers - LISW	Independent clinical social worker - LICSW
REGULATION/ACT: 1987	Licensure	Licensure	Licensure	Licensure
INITIAL LICENSURE/REGIST: Education:	Baccalaureate degree from accredited program in social work.	Master degree in social work.	Master's degree from accredited program of social work or doctoral. No clinical tract.	Masters plus. Master's work included a clinical tract.
EXPERIENCE:	Engage in social work under supervision for 50 hours during two years or 4,000 hours social work practice.	Consists of minimum of 50 hours every two year renewal by a licensed social worker.	Engage in social work under supervision for 50 hours during two years or 4,000 hours social work practice.	Engage in social work under supervision for 50 hours during two years or 4,000 hours social work practice.

ALTHOUGH THERE ARE 4 LICENSURE LEVELS THE REMAINING REQUIREMENTS ARE THE SAME FOR ALL LEVELS.

INITIAL LICENSURE :	INFORMATION FROM THE REGULATION AND INTERVIEW
Testing: National or state exam?	Pass written exam by the American Association of State Social Work Board.
RENEWAL REQUIREMENTS: CE: Hours/year/s	30 hours every 2 years.
Yearly fee:	$60.00 to $150.00 depending on level.
CEU, contact hours, self study	One continuing education hour is defined as a 60 minute clock hour containing at least 50 minutes of uninterrupted learning. One semester credit equals 15 continuing education hours. One quarter credit equals ten continuing hours.
Subjects or content	Most often academic study or research. Some stress management and evaluation measurement tools.
Proof of attendance. Documentation	Licensees must keep complete records for four years following renewal date.
Program provider requirements	N/A

OCCUPATION: SOCIAL WORK

Criteria for program approval.	Pre-approval requirement depends on program type. See attached sample of CE request form. Program types requiring pre-approval each have a limit of ten CE hours for each biennial renewal period. Sponsors must submit each program for approval.
Exceptions to approved programs.	None
ENFORCEMENT: Disciplinary actions if CE not completed?	N/A. Board of Social Work will be completing its first renewal period this year.

APPENDIX H.

REGULATED HEALTH CARE OCCUPATIONS
COMPARISON OF
COMPLAINT ACTIVITY AND AGENCY RESOURCES
FY 1990 DATA

2/20/91

REGULATED OCCUPATIONS	NUMBER OF PERSONS REGULATED	TOTAL COMPLAINTS RECEIVED	RATIO OF COMPLAINTS TO PERSONS REGULATED	NUMBER OF AGENCY STAFF (FTE's)	APPROPRIATION TO AGENCY (000)
Chiropractic	1,673	174	0.10	4.5	$271.7
Dentistry	10,468	229	0.02	6.83	$408.0
Hearing Instrument Selling	330	128	0.39	1.33	$50.0
Marriage, Family Therapy	780	22	0.03	3.33	$99.6
Unlicensed Mental Health Providers	600	72	0.12	3.33	$110.9
Mortuary Science	1,667	36	0.02	3.0	$124.0
Nursing	68,848	955	0.01	20.42	$1,106.4
Optometry	784	7	0.01	2.0	$74.6
Pharmacy	4,599	80	0.02	7.0	$386.2
Podiatry	122	26	0.21	0.45	$27.0
Psychology	2,309	230	0.10	3.5	$229.9
Physicians/Allied Practitioners	16,708	1119	0.07	12.58	$2,102.0
Social Work	7,805	94	0.01	3.33	$166.9
Veterinary Medicine	2,684	21	0.01	1.92	$99.0

Source: 1989-1990 Biennial Board Reports

Notes:
1. For all occupations except hearing instrument selling, complaints are referred to the Attorney General's Office for investigation and an enforcement recommendation.
2. All appropriation amounts include funding for legal services from the Attorney General's Office.

APPENDIX I.

MINNESOTA BOARD OF SOCIAL WORK
2700 University Avenue West, #225
St. Paul, MN 55114

(612) 643-2580

ceup app

SPONSOR APPLICATION FOR PRE-APPROVAL OF CONTINUING EDUCATION HOURS (CEHs)

TITLE OF PROGRAM:_____

DATE(S) SCHEDULED:_____

SPONSORING ORGANIZATION:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

CONTACT PERSON:_____PHONE NUMBER:_____

Instructions:

- Use exact titles, dates, and time periods.
- Type or print legibly using black ink.
- Answer the following items fully. Incomplete applications may be delayed substantially. Applicants may attach a program brochure that addresses some or all of the requested information in each of the items. If this is done, be sure to indicate where the requested information is located in the brochure.

1. AGENDA: Outline the agenda of the program. Clearly specify the time periods for coffee breaks, lunch breaks, and for each segment of the agenda, such as separate workshops.

2. **PROGRAM CONTENT:** Provide a statement regarding the overall content area of the program, the content of each segment of the program if it is not clearly indicated in the agenda, and what the relationship of the program is to the enhancement of social work practice, skills, knowledge, and/or values. Include a statement regarding the teaching methods to be used.

3. **PRESENTER'S CREDENTIALS:** Attach a resume, vita, or bio for each presenter that clearly indicates the work and educational experience of the presenter(s). Provide a statement regarding the selection process of the presenter(s) and the collaboration that has or will occur between the presenter(s) and the program organizers.

4. **EVALUATION OF THE PROGRAM:** Attach a copy of the evaluation instrument(s) that will be used. If the instrument(s) is/are in the development process, provide a description of the items to be included on the evaluation instrument(s). Measures should be established during the initial planning process in order to determine what the behavioral and informational objectives/outcomes for the participants are and what items would best measure these objectives/outcomes.

APPENDIX J.

MINNESOTA BOARD OF SOCIAL WORK
2700 University Avenue West, #225
St. Paul, MN 55114

(612) 643-2580

ceappl.frm

LICENSEE REQUEST FOR PRE-APPROVAL OF CONTINUING EDUCATION HOURS (CEHs)

NAME: _____ LICENSE#: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

HOME TELEPHONE:(___)_____ WORK TELEPHONE:(___)_____

This form may be used:

a) To obtain pre-approval for continuing education hours obtained through program types that require pre-approval; and

b) To obtain prior approval for continuing education hours obtained through program types that do not require prior approval before the licensee's renewal date. Licensees are encouraged to only obtain non-required prior approval for programs or activities that are ambiguous as to whether they have a focus relevant to social work.

The following outline lists the program types (see Minn. Rule 8740.0285, Subp.6), which require pre-approval (before the activity has begun), and which do not require prior approval before the licensee's renewal date. Continuing Education Hours (CEHs) must be earned in at least two of the outlined program types at the time of renewal.

PROGRAM TYPE	CEH ACTIVITY	APPROVAL REQUIREMENTS
One	A. Academic Coursework: Graduate	Prior Approval Not Required
One	B. Academic Coursework: Undergraduate	Prior Approval Not Required
One	C. Academic Coursework: Self-study	Pre-Approval Required
Two	CE Presentations Attended at National, International, Regional, or Sub-Regional Conferences or Associations	Prior Approval Not Required
Three	Workshops, Conventions, Conferences, and Seminars	Prior Approval Not Required
Four	Public or Private Staff Development Training Programs or Inservices	Prior Approval Not Required
Five	A. Individual Activities: Preparation Time for Presentations/Lectures	Pre-Approval Required
Five	B. Individual Activities: Research Time Leading to Publications	Pre-Approval Required
Six	Informal Study	Pre-Approval Required

The program types requiring pre-approval each have a limit of ten (10) continuing education hours that can be counted for each biennial renewal period.

Licensees are required to keep complete records, including verification of attendance forms, of all continuing education hours (CEHs) for four years following the renewal date for auditing purposes pursuant to Minn. Rule 8740.0285, Subp. 8.

Continuing Education Hours (CEHs) completed by licensees to meet the requirements of other boards or authorities will be accepted by the board as long as the program types and content areas fall within the guidelines set by the Board of Social Work.

Instructions:

1. Use exact course titles, dates, sponsors and hours.
2. Type or print legibly using black ink.

KEY: ** **CEHs in this category must be pre-approved; and no more than 10 CEHs can be counted in this category per each biennial renewal cycle.**

I. PROGRAM TYPE ONE: ACADEMIC COURSE WORK

One semester credit equals 15 continuing education hours. One quarter credit equals 10 continuing education hours. Credit for auditing a course will be actual clock hours attended not to exceed the academic credit.

A. GRADUATE LEVEL ACADEMIC COURSE WORK

Attach a statement that summarizes the content of the course.

FOR BOARD USE

DATE(S)	COURSE TITLE	SCHOOL, DEPT. & LOCATION	# OF CREDITS	SEMESTER, QUARTER, OR AUDIT	CE HOURS REQUESTED	HOURS APPVD & ICE#

B. UNDERGRADUATE ACADEMIC COURSE WORK

Because undergraduate course work is below a licensee's level of training, a statement on how the course work updates the licensee's current social work knowledge/skills must be attached along with a statement that summarizes the content of the course.

FOR BOARD USE

DATE(S)	COURSE TITLE	SCHOOL, DEPT. & LOCATION	# OF CREDITS	SEMESTER, QUARTER, OR AUDIT	CE HOURS REQUESTED	HOURS APPVD & ICE#

C. ACADEMIC COURSE WORK: SELF-STUDY**

Forms of study: correspondence course, televised course, audiovisual/video tapes, or other (specify). Attach a statement that summarizes the content of this course, a course outline, methods used, a tentative or actual bibliography, and a statement of anticipated final products/papers.

FOR BOARD USE

DATE(S)	COURSE TITLE	SCHOOL, DEPT. & LOCATION	FORM OF STUDY	# OF CRED.	SEMESTER, QUARTER, OR AUDIT	CE HRS RE-QUEST	HOURS APPVD & ICE#

II. PROGRAM TYPE TWO: CONTINUING EDUCATION PRESENTATIONS ATTENDED AT NATIONAL, INTERNATIONAL, REGIONAL, OR SUB-REGIONAL CONFERENCES OR ASSOCIATION MEETINGS

Attach a detailed agenda with break and lunch periods specified and a statement that summarizes the content of this conference or meeting.

FOR BOARD USE

DATE(S)	TITLE OF PRESENTATION	SPONSOR & LOCATION	CE HOURS REQUESTED	HOURS APPD & ICE#

III. PROGRAM TYPE THREE: WORKSHOPS/CONVENTIONS/CONFERENCES/SEMINARS

Attach a detailed agenda with break and lunch periods specified and a statement that summarizes the content of this program.

FOR BOARD USE

DATE(S)	TITLE	SPONSOR & LOCATION	CE HOURS REQUESTED	HOURS APPD & ICE#

IV. PROGRAM TYPE FOUR: PUBLIC OR PRIVATE STAFF DEVELOPMENT/TRAINING PROGRAMS OR INSERVICES

Primarily procedural or administrative focuses are not acceptable. Attach a detailed agenda with break and lunch periods specified and a statement that summarizes the content of this program.

FOR BOARD USE

DATE(S)	TITLE	AGENCY & LOCATION	CE HOURS REQUESTED	HOURS APPD & ICE#

V. PROGRAM TYPE FIVE: INDIVIDUAL ACTIVITIES**

A. RESEARCH/PREPARATION TIME LEADING TO PRESENTATIONS/LECTURES

Two hours of preparation time may be counted for every hour of presentation. The actual presentation time is not counted. Credit will be given only once regardless of the number of times the course was presented. Attach a statement of the content area to be researched and a tentative or actual bibliography. A detailed agenda for the presentation or lecture should also be attached, with break and lunch periods indicated.

FOR BOARD USE

DATE(S)	TITLE	SITE & LOCATION	CE HOURS REQUESTED	HOURS APPD & ICE#

B. RESEARCH TIME LEADING TO PUBLICATIONS

Attach a statement of the content area to be researched, a tentative or actual bibliography, and a statement describing the anticipated final publication.

FOR BOARD USE

DATE(S)	TITLE	INTENDED PUBLISHER	CE HOURS REQUESTED	HOURS APPD & ICE#

VI. PROGRAM TYPE SIX: INFORMAL STUDY**

Attach a statement of the content area to be researched, a tentative or actual bibliography, and a statement of the anticipated final product/paper.

FOR BOARD USE

DATE(S)	TOPIC	CE HOURS REQUESTED	HOURS APPD & ICE#

For Board Use Only:

Reviewed by:_____ Date:_____

Total CEHs requested:_____ Total CEHs approved:_____

Reasons for denial:_____

_____

_____